Members and non-contracted providers have the right to appeal claim determinations if they disagree with the decision. They must submit appeals within 65 days of the date of the plan decision notice. We'll work with the member or non-contracted provider if they have a good reason for missing the deadline or need more time.

Two kinds of Medicare member payment appeals

1. Appeals from the member or their legal representative

We'll review your appeal. If we find in your favor, we'll make payment at the applicable Medicare rate either to you or the provider. If we don't find fully in your favor, per the Medicare appeal process, we'll forward your case file to C2C Innovative Solutions, Inc. C2C Innovative Solutions, Inc. is an independent review entity contracted with the Centers for Medicare & Medicaid Services (CMS) for external reviews. C2C will notify you directly, in writing, of its decision. It may take longer if we need more information about the case. We'll tell the member or their legal representative if we do.

2. Appeals from non-contracted providers

We'll need a completed Waiver of Liability for all appeals from a non-contracted provider. Use the following link to get a copy of the waiver form: Provider Waiver of Liability We'll tell the provider if we need more information.

We'll review your appeal. If we find in your favor, we'll make payment at the applicable Medicare rate either to you or the member. If we don't find fully in your favor, per the Medicare appeal process, we'll forward your case file to C2C Innovative Solutions, Inc. C2C Innovative Solutions , Inc. is an independent review entity contracted with CMS for external reviews. C2C will notify you directly, in writing, of its decision.

Do you have a dispute about payments you would have received under Original Medicare? Then select here to follow the provider dispute process.

Help ensure member payment appeals and medical records go to the right place. Please follow timely processing requirements.

How to ask for an appeal

Step 1:

The **written request** must include:

- Member name
- Allina Health | Aetna Medicare member ID
- Reason for appeal
- Any evidence that the member or non-contracted provider wants us to review, such as doctors' letters or other information that explains why you feel payment should be made

Please submit all relevant medical records and supporting materials. They help us determine if the item or service is medically necessary. Types of records we may require are progress notes, imaging reports, office visit notes and therapy records. We may also ask for more information.

Step 2:

For a standard payment appeal, mail or fax to:

Allina Health | Aetna Medicare
Appeals Unit
PO Box 14067
Lexington, KY 40512

Standard appeal fax: **724-741-4953**

Questions?

Allina Health | Aetna Medicare: **1-833-570-6671 (TTY: 711)**