Aetna Better Health® of Illinois
Appeal and Grievance Quick Reference Guide

What is an appeal?
An appeal is the request for review of an Adverse Benefit Determination for both covered and non-covered items or services. An Adverse Benefit Determination is the denial or limitation of authorization of a requested service; the reduction, suspension, or termination of a previously authorized service; the denial of payment for a service; the failure to provide services in a timely manner; the failure to respond to an Appeal or Grievance in a timely manner; solely with respect to an MCO that is the only Contractor serving a Rural Area, the denial of an Enrollee's request to obtain services beyond the travel time and distance standards established for an Enrollee who lives in a Rural Area as set forth in section 5.8.1.1; or the denial of an Enrollee's request to dispute a financial liability including cost sharing.

Requests to appeal pre-service items on behalf of the enrollee are considered enrollee appeals and subject to the enrollee appeal timeframes and policies.

Requests to appeal post service items are always on behalf of the provider and considered a provider appeal subject to the provider appeal timeframes and procedures. They are not eligible for expedited processing.

Who can file an appeal?
A member appeal can be filed at any time by a member, or the member's appointed representative including a guardian, caregiver, relative, attorney or provider to represent the member throughout the appeal process. Representatives must be appointed in writing. The member can designate their representative in writing in any way or they can complete the Authorized Representative Form.

A provider appeal can be filed at any time by the provider or their appointed representative.

Ways to file an appeal
An appeal can be filed in writing or verbally within 60 days of the Adverse Benefit Determination, however verbal requests for appeals must be followed by a written request.

- A written member appeal should be submitted to the following address:

  Aetna Better Health of Illinois
  PO Box 81139
  5801 Postal Road
  Cleveland, OH 44181
  Email: **ILAppealandGrievance@aetna.com**

Fax: **1-844-951-2143**

- A written provider appeal should be submitted to the following address:
  Aetna Better Health of Illinois
  PO Box 81139
  5801 Postal Road
  Cleveland, OH 44181
  Email: **ILAppealandGrievance@aetna.com**
  Fax: **1-844-951-2143**

- A verbal appeal should be submitted to the following phone number:
  Aetna Better Health of Illinois - **1-866-329-4701 (TTY: 711)**

Aetna Better Health shall acknowledge receipt of each appeal in writing with the exception of member expedited appeals. Member expedited appeals are appeals where waiting the standard timeframe may cause harm to the members health. Member expedited appeals that meet criteria will be acknowledged verbally. Member expedited appeals that do not meet criteria will be transferred to standard processing and the member will be notified in writing within two (2) calendar days of receipt. All other member appeals will be acknowledged in writing within 3 business days of receipt.

Provider appeals received verbally will be acknowledged verbally at the time of receipt. All other provider appeals will be acknowledged in writing within 5 business days of receipt.

Appeal Timeframes and Notice Resolution

- Member standard appeals will be resolved within fifteen (15) business days from receipt of grievance
- Member expedited appeals will be resolved within 24 hours from receipt of all information not to exceed forty-eight (48) hours
- Provider appeals will be resolved within thirty (30) calendar days from receipt of the grievance

What is a grievance?
A member grievance is defined as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

Who can file a grievance?
A member grievance can be filed at any time by a member, the member's appointed representative including a guardian, caregiver, relative, attorney or provider to represent the member throughout the grievance process.

A provider grievance, also called a complaint, can be filed at any time by the provider or their appointed representative

Ways to file a grievance
A grievance can be filed verbally or in writing.

- A written member grievance should be submitted to the following address:

  Aetna Better Health of Illinois
  PO Box 81139
  5801 Postal Road
  Cleveland, OH 44181
  Email: **ILAppealandGrievance@aetna.com**
  Fax: **1-844-951-2143**

- A written provider grievance should be submitted to the following address:
  Aetna Better Health of Illinois
  PO Box 81139
  5801 Postal Road
  Cleveland, OH 44181
  Email: **ILAppealandGrievance@aetna.com**
  Fax: **1-844-951-2143**

- A verbal grievance should be submitted to the following phone number:
  Aetna Better Health of Illinois - **1-866-329-4701 (TTY: 711)**

Aetna Better Health shall acknowledge receipt of each grievance. Requests received verbally may be acknowledged at the time of receipt. If requested in writing, we will acknowledge member grievances within 3 business days of receipt and provider grievances within 5 business days of receipt.

Grievance Timeframes and Notice Resolution

- Member grievances will be resolved within ninety (90) calendar days from receipt of grievance
- Provider grievances will be resolved within thirty (30) calendar days from receipt of the grievance

For a full overview of the Aetna Better Health of Illinois' appeal and grievance policies please review the Aetna Better Health of Illinois website at **AetnaBetterHealth.com/Illinois-Medicaid**.