Meritain Health®
an aetna company

Appeal Request Form

NOTE: Completion of this form is mandatory. To obtain a review, submit this form with any necessary information needed to support your appeal. This may include medical records, office notes, discharge summaries, lab records and/or member history (this is not an all-inclusive list). Information can be sent to the address listed on your Explanation of Benefits (EOB) or other correspondence received from Meritain Health®.

Today's Date:____________ **Member Name:** ____________

Member ID Number: ____________ **Member Group Number:** ____________

Patient Name: ____________ **Birthdate (MM/DD/YYYY)):** ____________

NOTE: authorization form may be required for the appeal if it's for another person that's not the member/patient.

Type of Appeal: Medical ☐ Dental ☐ Vision ☐

What are you appealing?

Medical Necessity/Precertification ☐
Pricing Dispute (amount allowed) ☐
Benefit Level (percentage paid) ☐
Pre-Service ☐
Coordination of Benefits ☐
Coding Dispute ☐
Exclusion ☐

Provider Name: ____________ **TIN:**____________

Provider Address (Where appeal/complaint resolution should be sent)

____

Claim(s):____________ **Date of Service:** ____________

CPT/HPCS/Service being disputed:____________

Explanation of your request (please use additional pages if necessary):

Please return to:
Meritain Health Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

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