

Aetna Dental^R Administrators Grievance and Provider Nomination Form

Name of person completing this form	Date Completed	Email Address (To send final resolution)	Is this a complaint/ grievance or a request to solicit a provider to join the Aetna Dental Administrators Network?		
			<input type="checkbox"/> Complaint	<input type="checkbox"/> Provider Nomination	

Instructions to Member Services

- Member Services should attempt to resolve any calls relating to complaints/grievances.
- Provider services issues, provider billing issues, provider fee schedule issues and provider nominations should be submitted on this form.
- Complete the Form and E-Mail To: CrewsB@Aetna.com . Please fax any details (e.g. receipts or statements) to Brian at 860-754-0339.
- Please include copies of superbills if this issue pertains to discount fee disputes.
- Complaints and Grievances: Aetna will complete the review and return the issue determination to Member Services for final resolution with the subscriber.
- Provider Nominations: Aetna's Provider Relations team will evaluate the request. No follow up will be provided to the requestor.

PARTICIPANT INFORMATION:

Subscriber's Name			Subscriber's ID#			
Subscriber Address		City		State		Zip Code
Telephone # (Include Area Code)		Patient's Name		Patient's Relationship to Subscriber		

PROVIDER INFORMATION:

Provider Name			Telephone # (Include Area Code)			
Provider Address		City		State		Zip Code

PLEASE COMPLETE THIS SECTION FOR COMPLAINTS/GRIEVANCES. THIS SECTION DOES NOT NEED TO BE COMPLETED FOR PROVIDER NOMINATIONS.

Have the Services been rendered?	Yes _____ No _____	Date of the visit (if applicable) MMDDYY		Has the Subscriber or Patient been billed?	Yes _____ No _____	Has the Subscriber or Patient paid the bill?	Yes _____ No _____
Nature of the complaint:							
If the member is being billed above the negotiated fee:	ADA Code: _____	Fee charged: _____	Negotiated Fee: _____	ADA Code: _____	Fee charged: _____	Negotiated Fee: _____	ADA Code: _____
Fee Dispute Resolution:	Reimburse the member? Reimbursement amount \$ _____ Date member reimbursed _____						
	Yes _____ No, DDS honored _____						