Aetna Better Health® of Louisiana

Submit a grievance

If you need this in larger type or another format, call Member Services at **1-855-242-0802 (TTY: 711)**
Llame hoy mismo al **1-855-242-0802 (TTY: 711)** si usted desea recibir esta carta en español.

We believe that the member grievance (complaint) processes are essential in protecting the rights and health of our members and in identifying ways to improve our program operations and management. You may submit your grievance at any time. To submit a grievance in writing send us a letter telling us the details of your complaint or you may complete this form. Send your written request or this form by mail or fax:

Address:
Aetna Better Health of Louisiana
Grievance System Manager
PO Box 81139, 5801 Postal RD
Cleveland, OH 44181

Fax Number:
1-860-607-7657

You may also ask us to submit a grievance through our website at **AetnaBetterHealth.com/Louisiana**. Grievance requests can also be made by phone at **1-855-242-0802 (TTY: 711)**.

Who may make a request: Your or another individual (such as a family member or friend) that you want to act for you can submit a grievance. If you want someone to act for you, they must be your representative. Contact us to learn how to name a representative.

Member's Information

Member's Name _____ Date of Birth _____

Member's Address _____

City _____ State _____ Zip Code _____

Phone _____ Member's Plan ID Number _____

Complete the following ONLY if the person making this request is not the member:

Requestor's Name _____

Requestor's relationship to member _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for grievance requests made by someone other than member (if applicable see above under *Who may make a request*):

Attach documentation showing the authority to represent the member if it was not submitted previously. For more information on appointing a representative, contact us at **1-855-242-0802 (TTY: 711).**

Grievance details

Date grievance happened _____

Grievance description _____

_____

_____

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_____

Important note: Fast decisions, also called expedited decisions
You have to right to an expedited grievance decision.

- If you asked for a fast decision on a service or appeal and we decided to process it under our regular (non-expedited) time frame. If you have a supporting statement from your doctor, attach it to this request.
- If we took an extension to decide on your request for a service or an appeal.

☐ **Check this box if you are requesting an expedited grievance decision within 72 hours.**

Signature of person requesting the grievance:

_____ Date: _____