Medical Benefits Request

- Complete Sections I - 6.
- Sign Section 7 to have benefits paid to your doctor.
- Complete Employee Information on reverse side.
- If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
- Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:
  - patient's name
  - relationship to employee
  - date of service
  - type of service rendered
  - condition being treated
- If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipts must contain
  - drug name
  - purchase date
  - quantity
  - dose per/day
  - strength
  - physician name
  - charge
  - prescription number
  - pharmacy name/address
  - nature of illness or injury

  This information can be copied from the prescription bottle or box.
- Incomplete forms will delay payment.
- **Send the completed benefits request and the bills to the Aetna office that services your employer.**

  AETNA US Healthcare
  PO Box 981109
  El Paso, TX 79998-1109

If this information is missing, write it on the bill and sign your name.

1. Employer Information

Name (as shown on ID card)

Policy/Group Number

2. Employee Information

Social Security Number - -

Name

Birthdate (MM/DD/YYYY)

☐ Active ☐ Retired
Date of Retirement

Address (include zip code) ☐ Address is new

Daytime Telephone Number ( )

3. Patient Information

Social Security Number - -

Name

Birthdate (MM/DD/YYYY)

Relationship to Employee
☐ Self ☐ Spouse ☐ Child ☐ Other

Address (if different from employee)

Sex
☐ Male ☐ Female

Full Time Student
☐ No ☐ Yes

Expected Graduation Date

School Name

Marital Status
☐ Married ☐ Single

Is patient employed? ☐ No ☐ Yes
Date of Retirement

Name/Address of Employer

4. Other Coverage Information

Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan?
☐ No ☐ Yes

If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance or administrator

Member's Social Security Number - -

Member's Name

Member's Birthdate (MM/DD/YYYY)

5. Claim Information

If claim is for a laboratory test or doctors office visit, state diagnosis or nature of illness

Is claim related to employment?
☐ No ☐ Yes

Is claim related to an accident?
☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm

Description of accident

6. Release

To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorizations as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

7. Assignment

I authorize payment of medical benefits to the physician or supplier of service.

Patient's or Authorized Person's Signature _____ Date _____

For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. **Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

Provider's Statement

Employee Information

Name

Social Security Number

Patient's Name		Patient's Birthdate (MM/DD/YYYY)	
Date of Illness (first symptom) or injury (accident) or pregnancy (LMP)	Date first consulted you for this condition	If patient has had similar illness or injury, give dates	If an emergency check here ☐ emergency
Date patient able to return to work	Date of total disability from through	Date of partial disability from through	
Name of referring physician (e.g., Public Health Agency)		For services related to hospitalization give hospitalization dates admitted discharged	

Name & address of facility where services rendered (if other than home or office)

Diagnosis or nature of illness or injury (please indicate primary and secondary)

1.

2.

3.

4.

Procedures, Medical Services, Supplies Furnished

Date of Service	Place of Service*	Procedure Code Identify**	Description of Service	Type of Service †	Charges	Days or Units	Diagnosis Code††	Administrative Use Only

Physician's Name & Address (include zip code)	Telephone Number ( )	Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
	Patient Account Number	Total charge $ _____ Amount paid $ _____ Balance due $ _____
Physician's or supplier's signature		Date

* Place of Service Codes:

1 -	(IH)	- Inpatient Hospital	8 -	(SNF)	- Skilled Nursing Facility	1 -	Medical Care	8 -	Assistance at Surgery
2 -	(OH)	- Outpatient Hospital	9 -		- Ambulance	2 -	Surgery	9 -	Other Medical Service
3 -	(0)	- Office Visit	0 -	(OL)	- Other Location	3 -	Consultation	0 -	Blood or Packed Red Cells
4 -	(H)	- Patient Home	A -	(IL)	- Independent Laboratory	4 -	Diagnostic X-Ray	A -	Used DME
5 -		- Day Care Facility (PSY)	B -		- Other Medical Surgical Facility	5 -	Diagnostic Laboratory	M -	Alternate Payment for Maintenance Dialysis
6 -		- Night Care Facility (PSY)	C -	(RTC)	- Residential Treatment Center	6 -	Radiation Therapy	Y -	Second Opinion on Elective Surgery
7 -	(NH)	- Nursing Home	D -	(STF)	- Specialized Treatment Facility	7 -	Anesthesia	Z -	Third Opinion on Elective Surgery

† Type of Service Codes:

****Please Use Current Procedural Terminology Codes For Surgery**

†† Please Use ICD•9•CM For Discharge Diagnosis