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Aetna Voluntary Plans Benefits Request

Internal Use	
Category Code	VPCF
Office Key Code	039

☐ **Fixed Benefits Plan** ☐ **Hospital Plan**

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name	2. Policy/Group Number		3. Employee's Aetna ID Number
4. Employee's Name	5. Employee's Birthdate *(MM/DD/YYYY)*		6. ☐ Active ☐ Retired Date of Retirement
7. Employee's Address (include ZIP Code) ☐ Address is new			8. Employee's Daytime Telephone ( )
9. Patient's Name	10. Patient's Aetna ID	11. Patient's Birthdate *(MM/DD/YYYY)*	12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)			14. Patient's Gender ☐ Male ☐ Female
15. Patient's Marital Status ☐ Married ☐ Single	16. Is patient employed? ☐ No ☐ Yes	17. Name & Address of Employer	
18. Is claim related to an accident? ☐ No ☐ Yes If Yes, date _____ time _____ ☐ am ☐ pm			19. Is claim related to employment? ☐ No ☐ Yes
20. 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		21. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
22. Member's ID Number	23. Member's Name		24. Member's Birthdate *(MM/DD/YYYY)*

25. 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 authorization is as valid as the original.
Patient's or Authorized Person's Signature _____ Date _____

26. I authorize payment of medical benefits to the physician or supplier of service.
Patient's or Authorized Person's Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN, FACILITY OR SUPPLIER –

27. Name & Address of Facility where services rendered	**28**. For services related to hospitalization give hospitalization dates Admit Date: Discharge Date:	**29**. Bill Type (111 / 131)

30. Diagnosis Code(s) or ICDP(s)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____
1. Nature of illness or injury:

If **Aetna Voluntary Hospital Plan Claim:** Please provide an itemized bill or UB04 form from the hospital. The following information is required when submitting a claim for the Aetna Voluntary Hospital Plan **a.** Patient Name **b.** Date of Admission **c.** Date of Discharge **d.** Diagnosis Code(s) **e.** Number of Days Confined

Note: If an itemized bill is provided with no diagnosis code(s) the facility will have to provide a UB04 form or the facility will have to sign this document and list the diagnosis code(s). If the date span on the UB04 doesn't match the number of Room and Board days on claim form then an itemized bill will need to be provided.

31. TO BE COMPLETED BY PHYSICIAN OR SUPPLIER - PROCEDURES, MEDICAL SERVICES or SUPPLIES FURNISHED

Date of Service	Place of Service	Procedure Code	Description of Service	Type of Service	Charges	Days or Units	Diagnosis Code	Summary of Charges
								Total Charges $
								Amount Paid $
								Balance Due $

32. TO BE COMPLETED BY FACILITY, PHYSICIAN, or SUPPLIER

Physician's, Dentist's or Suppliers Name & Address (include ZIP Code)	Patient Account Number	Telephone Number ( )
	Taxpayer Identification Number	National Provider Identifier
	Physician's, Dentist's or Suppliers Signature	Date

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Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents:** ***For your protection California law requires notice of the following to appear on this form:*** *Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.* **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a statement of claim containing any materially **false** information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a **crime**. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Attention Oregon Residents: Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE PHYSICIAN OR SUPPLIER

1. Complete items 27 through 32 in full.
2. If the employee indicates that benefits should be paid directly to the physician or supplier, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

TO THE EMPLOYEE

1. Complete items 1 through 24 in full.
2. Please be certain to sign the authorization to release information in block 25.
3. If **Aetna Voluntary Hospital Plan Claim:** Please provide an itemized bill or UB04 form from the hospital. The following information is required when submitting a claim for the Aetna Voluntary Hospital Plan

   a. Patient Name **b.** Date of Admission **c.** Date of Discharge **d.** Diagnosis Code(s) **e.** Number of Days Confined

   Note: If an itemized bill is provided with no diagnosis code(s) the facility will have to provide a UB04 form or the facility will have to sign this document and list the diagnosis code(s). If the date span on the UB04 doesn't match the number of Room and Board days on claim form then an itemized bill will need to be provided.
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block 26.
5. Attach itemized bills or ask your health care provider to complete the applicable sections starting on block 27 of this document. The bills must include the following:
   a. Patient's name **b.** Condition being treated **c.** Type of service(s) rendered **d.** Date(s) of service(s) **e.** Relationship to employee
   Note: If this information is missing, write it on the bill and sign your name.
6. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:
   a. Drug name **b.** Purchase date **c.** Prescription number **d.** Pharmacy name/address **e.** Dose per/day **f.** Nature of illness or injury **g.** Quantity **h.** Charge **i.** Strength **j.** Physician's name
   Note: This information can be copied from the prescription bottle or box.
7. Retain copies of your bills for your record.

9. Send the completed benefits request and the bills to:

Aetna Voluntary Plans
PO Box 14079
Lexington, KY 40512-4079

Fax to: 1-859-455-8650
Phone: 1-888-772-9682