# Medical Benefits – Claim Instructions

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.
California Residents: 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.
**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.**
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.

**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 EMPLOYEE

1. Complete items one (1) through twenty-seven (27) in full. Be certain to sign the authorization to release information block (28).
2. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign the block (29).
3. 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.
4. 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
   - date(s) of service(s)
   - condition being treated
   - relationship to employee
   - type of service(s) rendered

   If this information is missing, write it on the bill and sign your name.
5. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:
   - drug name
   - dose per/day
   - charge
   - purchase date
   - nature of illness or injury
   - strength
   - prescription number
   - quantity
   - physician's name
   - pharmacy name/address

   This information can be copied from the prescription bottle or box.
6. Retain copies of your bills for your record.
7. Send the completed benefits request and the bills to : **Aetna Life Insurance Company**
   **P.O. Box 981106**
   **El Paso, TX 79998-1106**

## TO THE PHYSICIAN OR SUPPLIER

1. Complete items thirty (30) through forty-eight (48) 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.

Aetna®

# Medical Benefits Request

**Mail to: Aetna Life Insurance Company**
**P.O. Box 981106**
**El Paso, TX 79998-1106**

## TO BE COMPLETED BY EMPLOYEE

| | | | |
|---|---|---|---|
| 1. Employer's Name | | | 2. Policy/Group Number Branch Number |
| 3. Employee's 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 Number ( ) |

| | | | | |
|---|---|---|---|---|
| 9. Patient's Name | 10. Patient's ID Number | 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 Sex ☐ Male ☐ Female | 15. Full Time Student ☐ No ☐ Yes | 16. Patient's Expected Graduation Date | 17. Name of School City |
| 18. Patient's Marital Status ☐ Married ☐ Single | 19. Is patient employed? ☐ No ☐ Yes | 20. Name & Address of Employer | | |

| | |
|---|---|
| 21. 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 | 22. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator: |

| | | |
|---|---|---|
| 23. Member's ID Number | 24. Member's Name | 25. Member's Birthdate (MM/DD/YYYY) |
| 26. Is claim related to an accident? ☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm | | 27. Is claim related to employment? ☐ No ☐ Yes |

28. 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 _____

29. 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 OR SUPPLIER

| | | | |
|---|---|---|---|
| 30. Date of Illness (first symptom) or injury (accident) or pregnancy (LMP) | 31. Date first consulted you for this condition | 32. If patient has had similar illness or injury, give dates | 33. If an emergency check here ☐ emergency |
| 34. Date patient able to return to work | 35. Date of total disability from through | 36. Date of partial disability from through | |
| 37. Name of referring physician (e.g., Public Health Agency) | | 38. For services related to hospitalization give hospitalization dates admitted discharged | |
| 39. Name & address of facility where services rendered (if other than home or office) | | | |
| 40. Diagnosis or nature of illness or injury (please indicate primary and secondary) 1. 2. 3. 4. | | | |

### 41. 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 |
|---|---|---|---|---|---|---|---|---|
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|---|---|---|
| 42. Physician's Name & Address (include zip code) | 43. Telephone Number ( ) | 44. 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. |
| | 45. Patient Account Number | 46. Total charge $ _____ Amount paid $ _____ Balance due $ _____ |
| 47. Physician's or supplier's signature | | 48. Date |

* Place of Service Codes:

| | | | |
|---|---|---|---|
| 1 - (IH) | - Inpatient Hospital | 8 - (SNF) | - Skilled Nursing Facility |
| 2 - (OH) | - Outpatient Hospital | 9 - | - Ambulance |
| 3 - (O) | - Office Visit | 0 - (OL) | - Other Location |
| 4 - (H) | - Patient Home | A - (IL) | - Independent Laboratory |
| 5 - | - Day Care Facility (PSY) | B - | - Other Medical Surgical Facility |
| 6 - | - Night Care Facility (PSY) | C - (RTC) | - Residential Treatment Center |
| 7 - (NH) | - Nursing Home | D - (STF) | - Specialized Treatment Facility |

† Type of Service Codes:

| | |
|---|---|
| 1 - Medical Care | 8 - Assistance at Surgery |
| 2 - Surgery | 9 - Other Medical Service |
| 3 - Consultation | 0 - Blood or Packed Red Cells |
| 4 - Diagnostic X-Ray | A - Used DME |
| 5 - Diagnostic Laboratory | M - Alternate Payment for Maintenance Dialysis |
| 6 - Radiation Therapy | Y - Second Opinion on Elective Surgery |
| 7 - Anesthesia | Z - Third Opinion on Elective Surgery |

** Please Use Current Procedural Terminology Codes For Surgery

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