# CLAIM FORM

**Date Received:** _____

(To be used in connection with the Aetna CPT 77336 Claim Process)

## INSTRUCTIONS FOR COMPLETING CLAIM FORM

To participate in the Claim Process, as described in the accompanying Notice, you must complete this Claim Form and then mail it to the proper address as indicated in Section I below. If you wish to confirm that your Claim Form has been received by Aetna, send it by certified mail, return receipt requested. All information provided to Aetna shall be treated confidential under applicable law and contract.

**Section A - Provider Identification**

Indicate below the Provider's name and mailing address:

_____

Provider's Name (If you are filing your claim as a medical group, then insert the name of the medical group)

_____

Address

_____ _____ _____

City State Zip Code

_____

Provider's Tax Identification Number

**Section B - Authorized Agent Identification** (if applicable)

For purposes of this Claim Form and the Claim Process, an "Authorized Agent" is a person or entity that is the legal representative of the Provider, and which is authorized to act, make representations and waive claims on behalf of the Provider identified in Section A in reference to that Provider's CPT 77336 claims. If someone other than the Provider listed in Section A above is filing this Claim Form as an Authorized Agent, please indicate below the Authorized Agent's contact information:

_____

Authorized Agent's Name

_____

Address

_____ _____ _____

City State Zip Code

_____

Authorized Agent's Tax Identification Number

**Section C - Contact Person**

Indicate below the person to be contacted regarding this Claim Form and the person's contact information:

_____

Name of Contact

_____

Name of Company

_____ _____

Phone Number E-Mail Address

**MAIL THE COMPLETED CLAIM FORM AND SUPPORTING DOCUMENTATION TO AETNA, POSTMARKED ON OR BEFORE JANUARY 17, 2008.**

**Section D – Number of Claims**

Indicate below the number of claims you are seeking reimbursement for with this Claim Form:

_____

**Section E - Instructions Regarding Supporting Documentation**

In order for Aetna to reprocess your CPT 77336 claims, you need only submit **one** of the following:

(i) copies or reprints of a CMS 1500, UB 92, or equivalent electronic submission originally submitted to Aetna; **or**

(ii) copies of explanation of benefits forms for claims originally submitted to Aetna; **or**

(iii) a completed copy of the spreadsheet attached hereto; **or**

(iv) other documents that include the following information: the Provider's name, the Provider's tax identification number ("TIN"), the member's first and last names, the member's I.D. number, the date of service, the billed charge for CPT 77336, and the billed charge for the entire original claim submission.

This information can be submitted to Aetna in paper or electronic form. If you prefer to submit the information in electronic form, please download the supporting documentation to a computer disk and submit the disk along with the completed Claim Form. **Please keep a copy of all information submitted to Aetna.**

**Section F - Limited Release**

By submitting this Claim Form, the Provider listed in Section A (including all of its successors, affiliates, and affiliated individuals) hereby releases any and all claims against Aetna (including all of its successors, affiliates, employees and agents) that are, were or could have been, asserted in connection with any of the CPT 77336 claims for which reimbursement is now or could have been sought through the Claim Process.

**Section G - Certification**

By signing below, I (the Provider or its Authorized Agent) swear or affirm under penalty of perjury that: (1) I have authority to sign and submit this Claim Form either directly on behalf of the Provider, or as its Authorized Agent; (2) the information contained in this Claim Form is true and correct to the best of the Provider's knowledge and belief; (3) the Provider has not been reimbursed for any CPT 77336 claim that it has resubmitted with this Claim Form; (4) the Provider does not know of any other Claim Form being submitted for the claims being resubmitted with this Claim Form; (5) the Provider has not transferred or assigned its claims; and (6) the Provider acknowledges and agrees to the Limited Release of Claims set forth in Section F of this Claim Form. Furthermore, the Provider agrees to have its claims adjudicated by Aetna as outlined in the Agreement (discussed in the Notice).

Signature: _____ Dated: _____

_____ _____

(Print Your Name Here) (Title or Position if Provider or Authorized Agent is not an Individual)

**Section H - Getting More Information and Assistance**

You can call **Hanzman, Criden & Love** at **1-877-357-9001** (toll-free) or e-mail the firm at **klove@hanzmancriden.com**. Hanzman, Criden & Love has agreed to assist any Provider in the Claim Process **at no cost to the Provider**. In addition to any monies due to the Providers in this Claim Process, Aetna has agreed to pay Hanzman, Criden & Love its reasonable fees and costs related to the Claim Process.

**Section I - Mailing Instructions**

**YOU MUST RETURN THE COMPLETED CLAIM FORM AND SUPPORTING DOCUMENTATION SO THAT IT IS POSTMARKED ON OR BEFORE JANUARY 17, 2008.** (If the claim submission is not voluminous, you may also fax the documents on or before January 17**,** 2008.)

If you live in **California**, please send the completed Claim Form and Supporting Documentation to:

Attention: Provider Solutions Team Site Lead
5694 Mission Center Road, #602
PMB #297
San Diego, CA 92108;
or fax them to 860-907-4338.

If you live in the **District of Columbia, Maryland, North Carolina, South Carolina, Virginia or West Virginia**, please send the completed Claim Form and Supporting Documentation to:

Attention: Provider Solutions Team Site Admin.
4050 Piedmont Parkway
High Point, NC 27265;
or fax them to 860-754-9601.

If you live in **Iowa, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Ohio or Wisconsin**, please send the completed Claim Form and Supporting Documentation to:

Attention: Provider Solutions Team Site Admin.
7400 West Campus Road
New Albany, OH 43054;
or fax them to 860-754-5757.

If you live in **Connecticut, Delaware, Massachusetts, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island or Vermont**, please send the completed Claim Form and Supporting Documentation to:

Attention: Provider Solutions Team Site Admin.
Mail Stop U28B
1425 Union Meeting Road
Blue Bell, PA 19422;
or fax them to 860-902-2019.

If you live in **Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi or Tennessee**, please send the completed Claim Form and Supporting Documentation to:

Attention: Provider Solutions Team Site Admin.
Mailstop: F711
841 Prudential Drive
Jacksonville, FL 32207;
or fax them to 860-754-0875.

If you live in **Oklahoma, Puerto Rico or Texas**, please send the completed Claim Form and Supporting Documentation to:

Attention: Provider Solutions Team Site Admin.
4300 Centreway Place
Arlington, TX 76018;
or fax them to 860-902-2018.

If you live in **Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, North Dakota, Nebraska, New Mexico, Nevada, Oregon, South Dakota, Utah, Washington or Wyoming**, please send the completed Claim Form and Supporting Documentation to:

Attention: Provider Solutions Team Site Admin.
1800 E. Interstate Avenue
Bismark, ND 58503;
or fax them to 860-902-2014.

## Supporting Documentation

| Provider's Name (Group, Facility or Individual's Name ) | Provider's Tax ID Number | Member's First Name | Member's Last Name | Member's I.D. Number | Date of Service | Billed Charge for CPT 77336 Services | Billed Charge for the Entire Original Claim Submission in Which the Billed Charge Appears |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |