Aetna ExxonMobil Medical Plan Claim Form

- Complete Sections 2 - 6.
- Sign Section 7 to have benefits paid to your doctor.
- If you have submitted a claim for benefits to another plan, 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. The bills must include:
  - patient's name, date of birth and relationship to participant
  - date of service
  - procedure codes
  - cost of each service or supply
  - provider's name, address and tax identification number (TIN)

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

- Incomplete forms will delay payment.
- Send the completed claim form and the bills to:

  Aetna
  P.O. Box 14586
  Lexington, KY 40512-4586

- If you have questions, call Aetna at **800-255-2386.** Overseas, call collect **210-366-2416.**

1. Employer Information

Name: **EXXONMOBIL**

Policy/Group Number: **721000**

2. Participant Information

Member ID Number or Social Security Number

Name

Birthdate

☐ Employee ☐ Retiree ☐ Survivor ☐ COBRA

Address (include zip code)

Daytime Telephone Number ( )

3. Patient Information

Member ID Number or Social Security Number

Name

Birthdate

Relationship to Participant: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address (if different from participant)

Marital Status: ☐ Married ☐ Single

Sex: ☐ Male ☐ Female

Full-Time Student: ☐ No ☐ Yes

Is patient employed? ☐ No ☐ Yes

Name/Address of Employer

4. Other Coverage Information

Is patient 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 company or administrator

Member ID Number or Social Security Number

Insured's Name

Insured's Birthdate

5. Claim Information

Is claim related to an accident? ☐ No ☐ Yes If yes, date _____ time _____ ☐ a.m. ☐ p.m.

Is claim related to employment? ☐ No ☐ Yes

Description of Accident

6. Release

To all health care providers:
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 benefit calculation information used in payment of this claim for the purpose of reviewing the experience and operation of the plan. This authorization is valid for the term of the plan 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 _____

7. Assignment

Use of PPO Provider is an automatic assignment of benefits to the provider

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

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

Any person who knowingly and with intent to defraud or deceive the ExxonMobil Medical Plan files a statement of claim containing any materially false, incomplete or misleading information must repay any funds improperly received and may lose eligibility to participate in the ExxonMobil Medical Plan.

999-0236B (10/05)