aetna®

Medical Benefits Request

Mail to: Aetna Life Insurance Company
PO Box 981106
El Paso, TX 79998

TO BE COMPLETED BY MEMBER

1. School Name				2. Policy/Group Number
3. Member's Aetna ID Number	4. Member's Name			5. Member's Birthdate *(MM/DD/YYYY)*
6. Member's Address (include ZIP Code) ☐ Address is new				7. Member's Daytime Telephone Number ( )
8. Patient's Name	9. Patient's Aetna ID Number		10. Patient's Birthdate *(MM/DD/YYYY)*	11. Patient's Relationship to Member ☐ Self ☐ Spouse ☐ Child ☐ Other
12. Patient's Address (if different from member)	13. Patient's Gender ☐ Male ☐ Female	14. Full Time Student ☐ No ☐ Yes	15. Patient's Expected Graduation Date	16. Name of School and City
17. Patient's Marital Status ☐ Married ☐ Single	18. Is patient employed? ☐ No ☐ Yes		19. Name and Address of Employer	

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

21. Is claim related to employment? ☐ No ☐ Yes

22. 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

23. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:

24. Member's ID Number	25. Member's Name	26. Member's Birthdate *(MM/DD/YYYY)*

27. 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 _____

28. 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

29. Date of Illness (first symptom) or injury (accident) or pregnancy (LMP)	30. Date first consulted you for this condition	31. If patient has had similar illness or injury, give dates	32. If an emergency check here. ☐ emergency
33. Name of referring physician (e.g., Public Health Agency)		34. For services related to hospitalization give hospitalization dates admitted discharged	

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

36. Diagnosis or nature of illness or injury (please indicate primary and secondary)
1.
2.
3.
4.

37. 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 ††

38. Physician's Name & Address (include ZIP Code)	39. Telephone Number ( )	40. 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.
	41. Patient Account Number	42. Total charge $ _____ Amount paid $ _____ Balance due $ _____
43. Physician's or Supplier's Signature	44. National Provider Identifier	45. 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 Code for Discharge Diagnosis