



# Medical Benefits – Claim Instructions

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 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. **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.

Patient Signature:

Date:

**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-one (21) in full.
2. Complete items twenty-two (22) through twenty-six (26) only if other medical coverage exists.
3. Be certain to sign the authorization to release information in block twenty-seven (27).
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block twenty-eight (28).
5. 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.
6. Attach itemized bills with your receipts for proof of payment, or ask your health care provider to complete the applicable section on the reverse side.

The bills must include:

- patient's name
- condition being treated
- type of service(s) rendered
- date(s) of service(s)
- relationship to employee

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

7. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:
  - drug name
  - purchase date
  - prescription number
  - pharmacy name/address
  - dose per/day
  - nature of illness or injury
  - quantity
  - charge
  - strength
  - physician's nameThis information can be copied from the prescription bottle or box.
8. Retain copies of your bills for your record.
9. Refer to the back of your ID card for claim mailing address.

## TO THE PHYSICIAN OR SUPPLIER

1. Complete items twenty-nine (29) 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.



# Medical Benefits Request

Refer to the back of your ID card  
for claim mailing address

## 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. <input type="checkbox"/> Active <input type="checkbox"/> Retired<br>Date of Retirement   | 7. Employee's Address (include ZIP Code) <input type="checkbox"/> Address is new     |  | 8. Employee's Daytime Telephone Number<br>( )  |
| 9. Patient's Name   | 10. Patient's Aetna ID Number  | 11. Patient's Birthdate (MM/DD/YYYY)   | 12. Patient's Relationship to Employee<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other        |
| 13. Patient's Address (if different from employee)  |  |  | 14. Patient's Gender (If you prefer not to disclose, leave blank)<br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/Other |
| 15. Patient's Marital Status<br><input type="checkbox"/> Married <input type="checkbox"/> Single  | 16. Is patient employed?<br><input type="checkbox"/> No <input type="checkbox"/> Yes | 17. Name & Address of Employer   |  |
| 18. Is claim related to an accident?<br><input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm  |  |  | 19. Is claim related to employment?<br><input type="checkbox"/> No <input type="checkbox"/> Yes  |
| 20. If claim is related to medical services received outside of the U.S, what is the name of the country were you received services?  |  | 21. The services received outside of the U.S were for<br><input type="checkbox"/> Emergency care <input type="checkbox"/> Scheduled care |  |
| 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?<br><input type="checkbox"/> No <input type="checkbox"/> 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:<br>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.<br>Patient's or Authorized Person's Signature _____ Date _____ |  |  |  |
| 28. I authorize payment of medical benefits to the physician or supplier of service.<br>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<br><input type="checkbox"/> emergency   |          |               |                |
| 33. Date patient able to return to work  | 34. Date of total disability<br>from _____ through _____ | 35. Date of partial disability<br>from _____ through _____  |  |          |               |                |
| 36. Name of referring physician (e.g., Public Health Agency)   |  | 37. For services related to hospitalization give hospitalization dates<br>admitted _____ discharged _____ |  |          |               |                |
| 38. Name & address of facility where services rendered (if other than home or office)                        |  |   |  |          |               |                |
| 39. Diagnosis or nature of illness or injury (please indicate primary and secondary)<br>1.<br>2.<br>3.<br>4. |  |   |  |          |               |                |
| 40. Procedures, Medical Services, Supplies Furnished   |  |   |  |          |               |                |
| Date of Service  | Place of Service   | Procedure Code Identify   | Description of Service   | Charges  | Days or Units | Diagnosis Code |
|  |  |   |  |          |               |                |
|  |  |   |  |          |               |                |
|  |  |   |  |          |               |                |
|  |  |   |  |          |               |                |
| 41. Physician's Name & Address (include ZIP Code)  |  | 42. Telephone Number<br>( ) -   | 43. 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. _____ |          |               |                |
|  |  | 44. Patient Account Number  | 45. Total charge \$ _____<br>Amount paid \$ _____<br>Balance due \$ _____  |          |               |                |
| 46. Physician's or Supplier's Signature  |  | 47. National Provider Identifier  |  | 48. Date |               |                |

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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| English                 | To access language services at no cost to you, call the number on your ID card.  |
|-------------------------|--|
| Albanian                | Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.                              |
| Amharic                 | የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎች ላይ ያለውን ቁጥር ይደውሉ።  |
| Arabic                  | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.                                     |
| Armenian                | Ձեր նախընտրած լեզվով ավստի հարկհարկային սպասարկում համար գանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով |
| Bantu-Kirundi           | Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe  |
| Bengali                 | আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।  |
| Burmese                 | သင့်အနေဖြင့် အခကြေးငွေ မပေးရဲဘဲ ဘာသာစကားပြန်ဆောင်ရွက်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား ခေါ်ဆိုပါ။   |
| Catalan                 | Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.      |
| Cebuano                 | Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.                 |
| Chamorro                | Para un hago' i setbision lengguañhi ni dibåtde para hægu, ågang i numiru gi iyo-mu kard aidentifikasion.                        |
| Cherokee                | ᏐᏲᏊᏃ ᏚᏗᏔᏅᏊ ᏚᏓᏄᏛᏊ Ꮥ ᏆᏃᏊ ᏕᏒᏂᏛᏊ ᏆᏲ, ᏐᏃᏂᏛᏊ ᏐᏃᏲ ᏕᏆᏃᏊ ᏐᏆᏆᏃᏊ ᏕᏆᏆᏃᏊ ᏕᏆᏆᏃᏊ ᏕᏆᏆᏃᏊ.   |
| Chinese Traditional     | 如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼   |
| Choctaw                 | Anumpa tosholi i toksvli ya peh pillá ho ish i payahinla kv́t chi holisso kallo iskitini holhtena takanli ma i payah             |
| Chuukese                | Ren omw kopwe angei aninisín eman chón awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID                    |
| Cushitic-Oromo          | Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.             |
| Dutch                   | Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.  |
| French                  | Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.     |
| French Creole (Haitian) | Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.                           |
| German                  | Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.                |
| Greek                   | Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.                                   |
| Gujarati                | તમારે કોઈ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કોલ કરવો.                                  |
| Hawaiian                | No ka wala’au ‘ana me ka lawelawe ‘ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki ‘ole ‘ia kēia kōkua nei.          |
| Hindi                   | बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।                                     |

|                      |   |
|----------------------|---|
| Hmong                | Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.  |
| Igbo                 | Inweta enyemaka asụsụ na akwughị ụgwọ obula, kpọọ nọmba nọ na kaadi njirimara gi  |
| Ilocano              | Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.   |
| Indonesian           | Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.   |
| Italian              | Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.   |
| Japanese             | 無料の言語サービスは、IDカードにある番号にお電話ください。  |
| Karen                | လၢတၢ်ကမၤကျိၣ်တၢ်မၤစၢ်အတၢ်ဖံးတၢ်မၤတဖၣ်<br>လၢတၢ်အိၣ်ဒီးအပူၤလၢနကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ကိးဘၣ်လိတဲစီၣ်နီၣ်လၢအအိၣ်လၢနနီၣ်နီၣ် ၁ (၅၅)<br>အလီၤတက့ၤၼ်                          |
| Korean               | 무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.   |
| Kru-Bassa            | I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla  |
| Kurdish              | بۆ دەستگیرکردن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر نای دی (ID) کارتی خۆت.   |
| Lao                  | ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.  |
| Marathi              | आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.  |
| Marshallese          | Nan bōk jipañ kōn kajin ilo an ejjelōk wōṇean ṇan kwe, kwōn kallok nōmba eo ilo kaat in ID eo aṃ.   |
| Micronesian-Ponapean | Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.  |
| Mon-Khmer, Cambodian | ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។  |
| Navajo               | T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah nílįigo nanitinígíí bee néé'ho'dółzinígíí béésh bee hane'í biká'ígíí áají' hółne'. |
| Nepali               | भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।   |
| Nilotic-Dinka        | Të koor yin ran de wëër de thokic ke cîn wëu kor keek tënɔŋ yin. Ke yin col ran ye koc kuony në namba de abac tō në ID kard duön de tīt de nyin de panakim köu. |
| Norwegian            | For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.  |
| Pennsylvanian-Dutch  | Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.  |
| Persian Farsi        | برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.   |
| Polish               | Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.   |
| Portuguese           | Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.   |
| Punjabi              | ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।  |
| Romanian             | Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.  |

