Medical Benefits Request

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

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name **TEST EMPLOYER**			2. Policy/Group Number **X1999001**
3. Employee's Aetna ID Number **XEH111222333**	4. Employee's Name **TEST SUBSCRIBER**		5. Employee's Birthdate *(MM/DD/YYYY)* **09/01/1978**
6. ☐ Active ☐ Retired Date of Retirement	7. Employee's Address (include ZIP Code) ☐ Address is new **1234 TEST BLVD DUBLIN CA 94568**		8. Employee's Daytime Telephone Number (**111**) **222 6678**
9. Patient's Name **TEST PATIENT**	10. Patient's Aetna ID Number **XEH111222334**	11. Patient's Birthdate *(MM/DD/YYYY)* **01/01/2000**	12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)			14. Patient's Gender ☐ Male ☐ Female
15. Patient's Marital Status ☐ Married ☐ Single	16. Is patient employed? ☐ No ☑ Yes	17. Name & Address of Employer **1256 STAR BLVD DUBLIN CA 94568**	
18. Is claim related to an accident? ☐ No ☐ Yes If Yes, date _____ time _____ ☐ am ☐ pm			19. Is claim related to employment? ☐ No ☐ Yes
20. 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	21. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:		
22. Member's ID Number **XEH1112T223333**	23. Member's Name **TEST SUBSCRIBER**		24. Member's Birthdate *(MM/DD/YYYY)* **09/01/1978**

25. 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 **09/24/2019**

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

Patient's or Authorized Person's Signature _____ Date **09/24/2019**