



# 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 Date of Retirement	7. Employee's Address (include zip code) <input type="checkbox"/> Address is new		8. Employee's Daytime Telephone Number ( )
9. Patient's Name	10. Patient's Aetna ID Number	11. Patient's Birthdate (MM/DD/YYYY)	12. Patient's Relationship to Employee <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 Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	15. Full Time Student <input type="checkbox"/> No <input type="checkbox"/> Yes	16. Patient's Expected Graduation Date
17. Name of School	City		
18. Patient's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	19. Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes		20. Name & Address of Employer
21. Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm		22. Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes	
23. 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? <input type="checkbox"/> No <input type="checkbox"/> Yes		24. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
25. Member's ID Number	26. Member's Name		27. Member's Birthdate (MM/DD/YYYY)
28. 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 _____			
29. I authorize payment of medical benefits to the physician or supplier of service. <del>Patient's or Authorized Person's Signature</del> <b>PAYMENT GOES TO INSURED</b> <del>Date</del> <b>XXY</b>			

## TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

30. Date of illness (first symptom) or injury (accident) or pregnancy (LMP)	31. Date first consulted you for this condition	32. If patient has had similar illness or injury, give dates	33. If an emergency check here <input type="checkbox"/> emergency
34. Date patient able to return to work	35. Date of total disability from _____ through _____	36. Date of partial disability from _____ through _____	
37. Name of referring physician (e.g., Public Health Agency)		38. For services related to hospitalization give hospitalization dates admitted _____ discharged _____	
39. Name & address of facility where services rendered (if other than home or office)			
40. Diagnosis or nature of illness or injury (please indicate primary and secondary) 1. 2. 3. 4.			

## 41. 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 ††	Administrative Use Only

42. Physician's Name & Address (include zip code)	43. Telephone Number ( )	44. 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.
	45. Patient Account Number	
47. Physician's or supplier's signature	48. National Provider Identifier	46. Total charge \$ _____ Amount paid \$ _____ Balance due \$ _____
	49. Date	

\* Place of Service Codes:  
1 - (IH) - Inpatient Hospital  
2 - (OH) - Outpatient Hospital  
3 - (O) - Office Visit  
4 - (H) - Patient Home  
5 - Day Care Facility (PSY)  
6 - Night Care Facility (PSY)  
7 - (NH) - Nursing Home

8 - (SNF) - Skilled Nursing Facility  
9 - Ambulance  
0 - (OL) - Other Location  
A - (IL) - Independent Laboratory  
B - Other Medical Surgical Facility  
C - (RTC) - Residential Treatment Center  
D - (STF) - Specialized Treatment Facility

† Type of Service Codes:  
1 - Medical Care  
2 - Surgery  
3 - Consultation  
4 - Diagnostic X-Ray  
5 - Diagnostic Laboratory  
6 - Radiation Therapy  
7 - Anesthesia

8 - Assistance at Surgery  
9 - Other Medical Service  
0 - Blood or Packed Red Cells  
A - Used DME  
M - Alternate Payment for Maintenance Dialysis  
Y - Second Opinion on Elective Surgery  
Z - Third Opinion on Elective Surgery

\*\* Please Use Current Procedural Terminology Codes For Surgery  
†† Please Use ICD•9•CM For Discharge Diagnosis