



# Medical Benefits Request

## TO BE COMPLETED BY EMPLOYEE

1. Employer's Name		2. Policy/Group Number		Branch Number	
3. Employee's 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 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. 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		22. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:			
23. Member's ID Number		24. Member's Name		25. Member's Birthdate (MM/DD/YYYY)	
26. 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		27. Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes			
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. Patient's or Authorized Person's Signature _____ Date _____					

## 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		46. Total charge \$ _____ Amount paid \$ _____ Balance due \$ _____		
47. Physician's or supplier's signature						48. Date		

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|--------------------------------|--|---------------------------|--|
| * Place of Service Codes:      |  | † Type of Service Codes:  |  |
| 1 - (IH) - Inpatient Hospital  | 8 - (SNF) - Skilled Nursing Facility       | 1 - Medical Care          | 8 - Assistance at Surgery                      |
| 2 - (OH) - Outpatient Hospital | 9 - Ambulance                              | 2 - Surgery               | 9 - Other Medical Service                      |
| 3 - (O) - Office Visit         | 0 - (OL) - Other Location                  | 3 - Consultation          | 0 - Blood or Packed Red Cells                  |
| 4 - (H) - Patient Home         | A - (IL) - Independent Laboratory          | 4 - Diagnostic X-Ray      | A - Used DME                                   |
| 5 - Day Care Facility (PSY)    | B - Other Medical Surgical Facility        | 5 - Diagnostic Laboratory | M - Alternate Payment for Maintenance Dialysis |
| 6 - Night Care Facility (PSY)  | C - (RTC) - Residential Treatment Center   | 6 - Radiation Therapy     | Y - Second Opinion on Elective Surgery         |
| 7 - (NH) - Nursing Home        | D - (STP) - Specialized Treatment Facility | 7 - Anesthesia            | Z - Third Opinion on Elective Surgery          |