aetna®

Hospital and Fixed Indemnity Plan Claim Form

INTERNAL USE	
Category Code	VPCF
Office Key Code	039

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, 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 may have violated the state law. **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 (MM/DD/YYYY):**

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☐ **Fixed Benefits Plan** ☐ **Hospital Plan**

1. **Review your Plan Certificate for a list of benefits that are specifically covered under your plan.**
2. **Completing this form does not guarantee benefit payment.**
3. **Complete all sections fully as instructed below to speed up the claim processing.**
4. **Send this Claim form and hospital bills to: Aetna Voluntary Plans PO Box 14079 Lexington, KY 40512-4079 or Fax to: 1-859-455-8650**
   If you have any questions about your benefits or how to file a claim call our Customer Service Center at **1-800-607-3366 between 8:00 AM and 6:00 PM.**

MEMBER INSTRUCTIONS:

- **Complete sections A, B and H**
- **Complete section C if an inpatient stay occurred**
- **Complete section D if you are filing a claim for the health screening benefit**
- **Complete section E if an accident occurred**
- **Complete section F if you are filing a claim for the transportation benefit**
- **Complete section G if you are filing a claim for the lodging benefit**

PHYSICIAN / FACILITY INSTRUCTIONS:

- **Complete and submit sections I through L if the member has medical coverage with an insurance carrier other than Aetna.**

A. CHECK EACH BOX THAT IS RELATED TO YOUR CLAIM (please keep in mind that your plan may not include all the benefits listed below)

☐	Hospital stay - admission	☐	Hospital stay - daily
☐	Hospital stay - ICU admission	☐	Hospital stay - ICU daily
☐	Accidental injury treatment	☐	Observation unit
☐	Ambulance (ground/air)	☐	Outpatient surgery
☐	Emergency room	☐	Physician visit
☐	Equipment & supplies	☐	Prescription drug
☐	Health screening	☐	Rehabilitation unit stay - daily
☐	Home health care (inpatient or at home)	☐	Skilled nursing facility stay - daily
☐	Hospice care - daily	☐	Substance abuse stay - daily
☐	Inpatient surgery	☐	Therapy
☐	Lodging - daily stay	☐	Transportation
☐	Medical imaging	☐	Waiver of premium
☐	Mental disorder stay- daily	☐	X-ray and lab
☐	Newborn routine care		

B. 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. ☐ Active ☐ Retired Date of Retirement
7. Employee's Address (include ZIP Code) ☐ Address is new			8. Employee's Daytime Telephone ( )
9. Patient's Name	10. Patient's Aetna ID	11. Patient's Birthdate *(MM/DD/YYYY)*	12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)		14. Patient's Gender (If you prefer not to disclose, leave blank) ☐ Male ☐ Female ☐ Non-Binary/Other	
15. Patient's Marital Status ☐ Married ☐ Single	16. Is patient employed? ☐ No ☐ Yes	17. Name & Address of Employer	

Continued on next page

C. INPATIENT HOSPITAL STAY (to be completed by employee) Please complete this section if you are filing a claim related to an inpatient hospital stay.

1. Did the patient have an inpatient stay in the hospital? ☐ No ☐ Yes	2. Enter the inpatient start date *(MM/DD/YYYY)* / /	3. Enter the inpatient end date *(MM/DD/YYYY)* / /

4. Has similar condition happened in the past? ☐ Yes ☐ No
If Yes, state when and where.

D. HEALTH SCREENING (to be completed by employee) Please complete this section if you are filing a claim related to a Health screening benefit

1. Did you have a health screening test? ☐ No ☐ Yes	2. Enter the inpatient start date.	3. Date of your health screening test? *(MM/DD/YYYY)* / /

E. ACCIDENT DETAILS (to be completed by employee) Please complete this section if your injuries, inpatient stay or treatment was related to an accident.

1. Is claim related to an accident? ☐ No ☐ Yes	2. Is claim related to employment? ☐ No ☐ Yes	3. Where did it happen? ☐ On-Job ☐ Off-Job
4. Date of accident: _____		5. Time of accident: _____ ☐ am ☐ pm

6. Tell us exactly how your accident/injury happened.

F. TRANSPORTATION (to be completed by employee) Please complete the following information if you are filing a claim for transportation reimbursement. You will also need to send in any mileage information for the treating facility.

1. **Date** *(MM/DD/YYYY)*	2. Name of treating facility	3. Address	4. Mileage One way
/ /			
/ /			

G. LODGING (to be completed by employee) Please complete the following information if you are filing a claim for lodging reimbursement
You will also need to send in any hotel/motel receipts.

1. Date *(MM/DD/YYYY)*	2. Name of treating facility	3. Address	4. Mileage One way
/ / **to** / /			
/ / **to** / /			

H. AUTHORIZATION TO RELEASE INFORMATION

Do you have Major Medical Coverage with Aetna? ☐ Yes ☐ No

If yes and your provider has submitted your medical claim, you may not need to attach supporting documentation or have your provider complete the Attending Physician Statement

If no, you will need to have your provider complete the Attending Physician Statement(s) and/or submit supporting documentation.

For the purpose of evaluating and administering my claim for benefits, I hereby authorize the disclosure of information concerning health care advice, treatment or supplies (including that related to mental illness and HIV) provided to me and, if applicable, my dependents, to Aetna Life Insurance Company (Aetna) and its affiliates and authorized representatives. If applicable, I also authorize the disclosure of information concerning my employment. This authorization is valid for the term of the policy or certificate under which the claim has been submitted. I know that I may request a copy of this authorization, and I agree that a copy of this authorization is as valid as the original.

Signature	**Printed name**	**Date (MM/DD/YYYY)** / /

If the person signing is the legal Guardian, Power of Attorney Designee, or personal representative, please sign and print your name and indicate the relationship here.

Signature	**Printed name**	**Relationship**

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM.

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Patient's Name	Patient's Birthdate *(MM/DD/YYYY)* / /

I. ATTENDING PHYSICIAN STATEMENT (to be completed by facility)

1. Name & Address of Facility where services rendered	2. For services related to hospitalization give hospitalization dates Start Date: End Date:	3. Bill Type (111/131)

4. Diagnosis Code(s) or ICDP(s)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____

Description of illness or injury:

Hospital stay type: ☐ Inpatient ☐ Outpatient ☐ Observation	Date of Inpatient Admission:
5. Room and Board Revenue Codes: # of days in room Room and Board Revenue Codes: # of days in room	6. Observation Room Revenue Code: # of hours in observation Observation Room Revenue Code: # of hours in observation

J. FACILITY VERIFICATION

1. Print full name		2. Tax identification number
3. Signature	4. Date (MM/DD/YYYY) / /	5. Phone number ( ) -
6. Street address, city, state and ZIP code		

K. ATTENDING PHYSICIAN STATEMENT (to be completed by physician)

1. Date of Service	2. Place of Service	3. Procedure Code(s)	4. Description of Service(s)
5. Billed Amount	6. Days/Units	7. Diagnosis Codes	

L. PHYSICIAN VERIFICATION

1. Print full name		2. Tax identification number
3. Signature	4. Date (MM/DD/YYYY) / /	5. Phone number ( ) -
6. Street address, city, state and ZIP code		

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM.

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
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
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
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 કોઇ પણ તના ખર્ચ ના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇ કાડપર રહેલ નંબર પર કૉલ કરવો.
Hindi	बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, अपने आइड काडर् पर दए नंबर पर कॉल कर।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
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	လၢကမၤန့ၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိဉ်လၢာ်ဘူဉ်လၢာ်စ့ လၢနဂီၢ်အဂီၢ်, ကိးနီဉ်ဂံၢ် လၢအအိဉ် ဖဲန ID အဖိခိဉ်နှဉ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមរទូរសព្ទកាន់លេខដែលមាននលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah nílíígo nanitinígíí bee nééhoʼdólzinígíí béésh bee hane'í biká'ígíí áaji' hólne'.
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 ਬਿਨਾ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆ ਪੰਜਾਬੀ ਸੇਵਾਵਾ ਦੀ ਵਰਤੋ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܐܢ ܒܥܝܬܐ ܬܠܘܢ ܥܠ ܫܠܡܘܬܐ ܕܡܫܡܫܢܘܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ، ܩܪܘ ܠܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܗܝܝܘܬܐ ܕܝܠܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнј отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.