Medical Benefits Request

- Complete Sections 1 - 6.
- Sign Section 7 to have benefits paid to your doctor.
- Complete Employee Information on reverse side.
- 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.
- Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:
  - patient's name
  - relationship to employee
  - date of service
  - type of service rendered
  - condition being treated

  If this information is missing, write it on the bill and sign your name.
- If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipts must contain:
  - drug name
  - purchase date
  - quantity
  - dose per/day
  - strength
  - physician name
  - charge
  - prescription number
  - pharmacy name/address
  - nature of illness or injury

  This information can be copied from the prescription bottle or box.
- Incomplete forms will delay payment.
- **Send the completed benefits request and the bills to the Aetna office that services your employer.**

1. Employer Information

Name (as shown on ID card): AGMA Health Fund

Policy/Group Number: 724290

2. Employee Information

Social Security Number: – –

Name

Birthdate (MM/DD/YYYY)

☐ Active ☐ Retired
Date of Retirement

Address (include zip code) ☐ Address is new

Daytime Telephone Number ( )

3. Patient Information

Social Security Number: – –

Name

Birthdate (MM/DD/YYYY)

Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address (if different from employee)

Sex: ☐ Male ☐ Female

Full Time Student: ☐ No ☐ Yes

Expected Graduation Date

School Name

Marital Status: ☐ Married ☐ Single

Is patient employed? ☐ No ☐ Yes
Date of Retirement

Name/Address of Employer

4. Other Coverage Information

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

If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:

Member's Social Security Number: – –

Member's Name

Member's Birthdate (MM/DD/YYYY)

5. Claim Information

If claim is for a laboratory test or doctors office visit, state diagnosis or nature of illness

Is claim related to employment? ☐ No ☐ Yes

Is claim related to an accident?
☐ No ☐ Yes If yes, date ____________ time ____________ ☐ am ☐ pm

Description of Accident

6. Release

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 __________

7. Assignment

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

Patient's or Authorized Person's Signature ______________________ Date __________

For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. **Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

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