

Subscriber's name _____ Aetna U.S. Healthcare® ID number _____

Patient's name _____

1. Was a referral obtained from your primary care physician or did you utilize your out-of-network benefit?

Primary care physician Self-referred in-network Self-referred out-of-network

2. Who in your family is covered by another group health plan? _____

What is the name and address of the company and the policy number? _____

3. Is this claim due to an injury? Yes No If yes, did the injury occur while at work? Yes No

If yes, how, when and where did it happen? _____

4. To speed processing, please give us your telephone number. _____

New address (if applicable) _____

5. Send payment to: Provider Employee/Member

Date _____ Employee signature _____

**PLEASE SEND THE ORIGINAL BILLS—NOT PHOTOCOPIES.
If any bills have been paid, please mark them “paid.”**

Important: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTE: Voluntarily seeking care outside the HMO network requires you to assume a substantial increase in your out-of-pocket expenses. Care provided within the HMO network would be provided at a much lower out-of-pocket cost to you.