Ætna US Healthcare

Medical Benefits Request

SBM-025

Patient Instructions

- Complete Sections 1a - 11.
- Sign Section 12 to authorize the release of information by health care providers as described below.

> 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 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. You have a right to receive a copy of this authorization upon request and by signing the authorization you agree that a photographic copy of this authorization is as valid as the original.

- Sign Section 13 to have benefits paid to your doctor.
- 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
  - nature of illness or injury
  - pharmacy name/address

  This information can be copied from the prescription bottle or box.

> Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: 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.
> **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.**

- Incomplete forms will delay payment.
- Send the completed benefit request and the bills to:

Aetna
P.O. Box 14100
Lexington, KY 40512

If you have questions
CALL TOLL FREE

1-800-843-5869

GC-50 (1-01)

See Completion Instructions on Reverse *(please print or type)*

1.

1a. Employee's ID/SSN Number

2. Patient's Name (Last Name, First Name, Middle Initial)

3. Patient's Birth Date MM | DD | YYYY Sex M ☐ F ☐

4. Employee's Name (Last Name, First Name, Middle Initial)

5. Patient's Address (No. Street)

6. Patient Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other ☐

7. Insured's Address (No. Street)

City State

8. Patient Status Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

City State

Zip Code Telephone (Include Area Code) ( )

Zip Code Telephone (Include Area Code) ( )

9. Other Insured's Name (Last Name, First Name, Middle Initial)

a. Other Insured's Group Policy Number

b. Other Insured's Birth Date MM | DD | YYYY Sex M ☐ F ☐

c. Employer's Name

d. Insurance Plan Name

10. Is patient condition related to:

a. Employment? (current or previous) ☐ Yes ☐ No

b. Auto accident? ☐ Yes ☐ No Place (state) ____

c. Other accident? ☐ Yes ☐ No

10d. ☐ Employee Active ☐ Employee Retired Date of Retirement:

11. Employee's Group Policy Number

a. Employee's Birth Date MM | DD | YYYY Sex M ☐ F ☐

b. Employer's Name

c. Insurance Plan Name

d. Do you or your family members have other group health coverage? ☐ Yes ☐ No *If **yes**, return to an complete item 9 a-d.*

12. ***Note: Read the statement on back of this form before signing this authorization.***
I authorize the release of information as described on the reverse of this form.

Patient's or Authorized Person's Signature Date

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

Patient's or Authorized Person's Signature Date

14. Date of Current MM | DD | YYYY ◀ Illness (first symptom) or Injury (accident) or Pregnancy (LMP)

15. If patient has had same or similiar illness, give first date MM | DD | YYYY

16. Date patient unable to work in current occupation From MM | DD | YYYY To MM | DD | YYYY

17. Name of Referring Physician or Other Source

17a. I.D. Number of Referring Physician

18. Hospitlization dates related to current services From MM | DD | YYYY To MM | DD | YYYY

19. Date first consulted you for this condition.

20. Outside Lab? ☐ Yes ☐ No $ Charges

21. Diagnosis or nature of illness or injury. (related items 1,2,3,or 4 to item 24E by line)

1. |_____ . ___ 3. |_____ . ___

2. |_____ . ___ 4. |_____ . ___

22. Medicaid Resubmission Code | Original Ref. No.

23. Prior Authorization Number

24. A Date(s) of Services From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies (explain unusual circumstances) CPT/HCPCS Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved For Local Use
1										
2										
3										
4										
5										
6										

25. Federal Tax I.D. Number SSN ☐ EIN ☐

26. Patient's Account No.

27. Accept Assignment ☐ Yes ☐ No

28. Total Charge $

29. Amount Paid $

30. Balance Due $

31. Signature of physician or supplier including degrees or credentials.
Signed ____________
Date

32. Name and address of facility where services were rendered (if other than home or office)

33. Physician's, Supplier's Billing Name, Address , Zip Code & Phone #
PIN # | GRP #