



# 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
    - date of service
    - condition being treated
    - relationship to employee
    - type of service rendered
- 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.**

<b>1. Employer Information</b>	Name (as shown on ID card) <b>AGMA Health Fund</b>		Policy/Group Number <b>724290</b>	
<b>2. Employee Information</b>	Social Security Number - -	Name	Birthdate (MM/DD/YYYY)	
	<input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement	Address (include zip code) <input type="checkbox"/> Address is new	Daytime Telephone Number ( )	
<b>3. Patient Information</b>	Social Security Number - -	Name	Birthdate (MM/DD/YYYY)	
	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Address (if different from employee)	
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Full Time Student <input type="checkbox"/> No <input type="checkbox"/> Yes	Expected Graduation Date	School Name
	Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Retirement	Name/Address of Employer		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
<b>4. Other Coverage Information</b>	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		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)	
<b>5. Claim Information</b>	If claim is for a laboratory test or doctors office visit, state diagnosis or nature of illness		Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes	
	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			
	Description of Accident			
<b>6. Release</b>	<p>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.</p> <p>Patient's or Authorized Person's Signature _____ Date _____</p>			
<b>7. Assignment</b>	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. <b>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.</b>			