Medicare Medical Claim Reimbursement Instructions

aetna™

How to complete this Medical Claim Reimbursement Form

When to use this form?

1. Fill out this form if you're asking for a medical, dental, vision, hearing, or vaccine reimbursement and you paid a doctor, healthcare professional, or service provider who did not bill us directly.
2. Don't use this form for prescription drug claim reimbursements. Visit **www.aetnamedicare.com** or call the member services number on your Aetna member ID card for a prescription drug claim form.

How to fill out this form?

1. Complete each section. Print clearly in black ink only, or type the information in the form online.
2. Sign and date the bottom of the completed form. Appointed representatives must have an Appointment of Representative form on file with the health plan, or you can submit one with this form. You can find an Appointment of Representative form on **www.aetnamedicare.com**.

Where to send the completed form?

1. Make copies of all of your receipts and itemized bills from your provider. Be sure to include your Aetna member ID number on each receipt and bill. All materials submitted will be retained by us and cannot be returned to you.
2. Mail this completed form and your original receipts and itemized bills to the medical claims address on your Aetna Medicare member ID card.
3. Or you can fax this completed form, your original receipts and itemized bills to **1-866-474-4040**.

Things to remember

1. Please submit this form within 365 days from the date you received the service or item.
2. If your request is incomplete, we'll return it to you and this will delay processing.
3. If the provider you paid is contracted with us, we will always pay the provider directly at the contracted rate. You should ask the provider to pay you back.
4. If we approve your request, it can take up to 45 days to send payment once we have all the required information.

Questions?

We're here to help. Just give us a call at the number on your Aetna Medicare member ID card.

Acknowledgement

You understand it is a crime to fill out this form with information you know is false. You understand that submission of a claim is not a guarantee of payment, or payment in the full amount. You understand if the services are deemed covered services then the health plan will reimburse you up to the benefit amount minus any applicable deductibles, coinsurance, or copayments. You understand we may need to disclose the information on the form to other persons and entities to process the claim.

Member information *(print clearly)*

Aetna member ID number:

Date of birth ***(MM/DD/YYYY):*** / /

Male **Female**

Last name: **First name:** **Middle initial:**

Street address:

City: **State:** **code:**

Phone number ***(with area code):*** – – **Email address:**

Doctor, healthcare professional or supplier information

Provider or supplier name:

Provider NPI#:

Street address:

City: **State:** **code:**

Phone number ***(with area code):*** – – **Email address:**

Claim request *(information must match your itemized bill)*

Date of service ***(MM/DD/YYYY):*** / /

Amount paid: $, .

Reimbursement type:

- Medical
- Dental
- Vision
- Hearing
- Vaccine
- Other

Description of procedure(s), service(s), or item(s) ***(include procedure code if available)*****:**

Signature

By signing and submitting this form, you certify that the information is true and correct.

Member or authorized representative signature

Date

Proprietary