



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:
AETNA CLAIM OFFICE, P.O. BOX 14079, Lexington, KY 40512
Claim Questions: call toll-free at 1 (888) 553-3449.

1. Employer	Name (as shown on ID card) COX ENTERPRISES, INC.		Policy/Group Number 779409
2. Employee Information	Social Security Number	Name	
	<input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement	Address (include zip code) <input type="checkbox"/> Address is new Phone #	
3. Patient Information	Social Security Number	Name	
	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	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	
	Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Retirement:	Name/Address of Employer	
4. Other Coverage Information	Are any family members expenses covered by another health plan, group pre-payment plan (Blue Cross/Shield, etc.), 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
5. Claim Information	If claim is for 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		
6. Release	<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>		
7. Assignment	I authorize payment of medical benefits to the physician or supplier of service.		
	<p>Patient's or Authorized Person's Signature _____ Date _____</p> <p>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, may be subject to fines, confinement in state prison and may be liable for 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.</p>		
8. Preventive Care Benefit	<input type="checkbox"/> By marking this box, I request these preventive care expenses be reimbursed from my preventive care benefit for either myself or my covered Spouse. Signature _____ Date _____		

Provider's Statement

Employee Information

Number

Patient's Name		Patient's Birthdate	
Date of illness (first symptom) or injury (accident) or pregnancy (LMP)	Date first consulted for this condition	If patient has had similar illness or injury, give dates	If an emergency check here <input type="checkbox"/> emergency
Date patient able to return to work	Date of total disability From Through		Date of partial disability From Through
Name of referring physician (e.g., Public Health Agency)		For services related to hospitalization give hospitalization dates Admitted Discharged	

Name & address of facility where services rendered (if other than home or office)

Diagnosis or nature of illness or injury (please indicate primary and secondary)

- 1.
- 2.
- 3.
- 4.

Procedures, Medical Services, Supplies Furnished

Date of Service	Place of Service*	Procedure Code Identify**	Description of Service						

Physician's Name & Address (include zip code)	Telephone Number	Enter the taxpayer identifying number used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.	
	Patient Account Number	Total Charge	\$ _____
		Amount paid	\$ _____
		Balance due	\$ _____

Physician's or supplier's signature

<p>*Place of Service Codes:</p> <ul style="list-style-type: none"> 1 - (IH) - Inpatient Hospital 2 - (OH) - Outpatient Hospital 3 - (O) - Office Visit 4 - (H) - Patient Home 5 - - Day Care Facility (PSY) 6 - - Night Care Facility (PSY) 7 - (NH) - Nursing Home 8 - (SNF) - Skilled Nursing Facility 9 - - Ambulance 0 - (OL) - Other Location A - (IL) - Independent Laboratory B - - Other Medical Surgical Facility C - (RTC) - Residential Treatment Center D - (STF) - Specialized Treatment Facility 	<p>+Type of Service Codes:</p> <ul style="list-style-type: none"> 1 - Medical Care 2 - Surgery 3 - Consultation 4 - Diagnostic X-Ray 5 - Diagnostic 6 - Radiation Therapy 7 - Anesthesia 8 - Assistance at Surgery 9 - Other Medical Service 0 - Blood or Packed Red Cells A - Used DME M - Alternate Payment for Maintenance Dialysis Y - Second Opinion on Elective Surgery Z - Third Opinion on Elective Surgery
<p>** Please Use Current Procedural Terminology Codes For Surgery Diagnosis</p>	<p>++ Please Use ICD9eCM For Discharge</p>