Aetna® Medical Benefits Request

Refer to the back of your ID card for claim mailing address

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name			2. Policy/Group Number
3. Employee's Aetna ID Number	4. Employee's Name		5. Employee's Birthdate *(MM/DD/YYYY)*
6. ☐ Active ☐ Retired Date of Retirement	7. Employee's Address (include zip code) ☐ Address is new		8. Employee's Daytime Telephone Number ( )
9. Patient's Name	10. Patient's Aetna ID Number	11. Patient's Birthcate *(MM/DD/YYYY)*	12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)	14. Patient's Gender ☐ Male ☐ Female / 15. Full Time Student ☐ No ☐ Yes	16. Patient's Expected Graduation Date	17. Name of School and City
18. Patient's Marital Status ☐ Married ☐ Single	19. Is patient employed? ☐ No ☐ Yes	20. Name & Address of Employer	
21. Is claim related to an accident? ☐ No ☐ Yes If Yes, date _____ time _____ ☐ am ☐ pm			22. Is claim related to employment? ☐ No ☐ Yes
23. 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? ☐ No ☐ Yes		24. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
25. Member's ID Number	26. Member's Name		27. Member's Birthdate *(MM/DD/YYYY)*

28. 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.
Patient's or Authorized Person's Signature _____ Date _____

29. I authorize payment of medical benefits to the physician or supplier of service.
Patient's or Authorized Person's Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

30. Date of Illness (first symptom) or injury (accident) or pregnancy (LMP)	31. Date first consulted you for this condition	32. If patient has had similar illness or injury, give dates	33. If an emergency check here ☐ emergency
34. Date patient able to return to work	35. Date of total disability from through	36. Date of partial disability from through	
37. Name of referring physician (e.g., Public Health Agency)		38. For services related to hospitalization give hospitalization dates admitted discharged	
39. Name & address of facility where services rendered (if other than home or office)			
40. Diagnosis or nature of illness or injury (please indicate primary and secondary) 1. 2. 3. 4.			

41. Procedures, Medical Services, Supplies Furnished

Date of Service	Place of Service*	Procedure Code Identify**	Description of Service	Type of Service †	Charges	Days or Units	Diagnosis Code ††	Administrative Use Only

42. Physician's Name & Address (include zip code) International Medical Group P.O. Box 30073 Grand Cayman KY1-1201 Cayman Islands Tel: (345) 945-2881 Fax: (345) 949-4341	43. Telephone Number ( )	44. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.
	45. Patient Account Number	46. Total charge $ _____ Amount paid $ _____ Balance due $ _____
47. Physician's or Supplier's Signature	48. National Provider Identifier	49. Date

*** Place of Service Codes:**

1 - (IH)	- Inpatient Hospital	8 - (SNF)	- Skilled Nursing Facility
2 - (OH)	- Outpatient Hospital	9 -	- Ambulance
3 - (O)	- Office Visit	0 - (OL)	- Other Location
4 - (H)	- Patient Home	A - (IL)	- Independent Laboratory
5 -	- Day Care Facility (PSY)	B -	- Other Medical Surgical Facility
6 -	- Night Care Facility (PSY)	C - (RTC)	- Residential Treatment Center
7 - (NH)	- Nursing Home	D - (STF)	- Specialized Treatment Facility

** Please Use Current Procedural Terminology Codes For Surgery

†Type of Service Codes:

1 - Medical Care	8 - Assistance at Surgery
2 - Surgery	9 - Other Medical Service
3 - Consultation	0 - Blood or Packed Red Cells
4 - Diagnostic X-Ray	A - Used DME
5 - Diagnostic Laboratory	M - Alternate Payment for Maintenance Dialysis
6 - Radiation Therapy	Y - Second Opinion on Elective Surgery
7 - Anesthesia	Z - Third Opinion on Elective Surgery

††Please Use ICD•9•CM For Discharge Diagnosis