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 Birthdate *(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. Patient's Marital Status ☐ Married ☐ Single	16. Is patient employed? ☐ No ☐ Yes	17. Name & Address of Employer	
18. Is claim related to an accident? ☐ No ☐ Yes If Yes, date _____ time _____ ☐ am ☐ pm			19. Is claim related to employment? ☐ No ☐ Yes
20. If claim is related to medical services received outside of the U.S, what is the name of the country were you received services?		21. The services received outside of the U.S were for ☐ Emergency care ☐ Scheduled care	
22. 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		23. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
24. Member's ID Number	25. Member's Name		26. Member's Birthdate *(MM/DD/YYYY)*

27. 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 _____

28. 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

29. Date of Illness (first symptom) or injury (accident) or pregnancy (LMP)	30. Date first consulted you for this condition	31. If patient has had similar illness or injury, give dates	32. If an emergency check here ☐ emergency
33. Date patient able to return to work	34. Date of total disability from through	35. Date of partial disability from through	
36. Name of referring physician (e.g., Public Health Agency)		37. For services related to hospitalization give hospitalization dates admitted discharged	

38. Name & address of facility where services rendered (if other than home or office)
South Chesapeake Psychiatry 200 Carmichael Way, Suite 604 Chesapeake, VA 23322

39. Diagnosis or nature of illness or injury (please indicate primary and secondary)
1.
2.
3.
4.

40. Procedures, Medical Services, Supplies Furnished

Date of Service	Place of Service	Procedure Code Identify	Description of Service	Charges	Days or Units	Diagnosis Code

41. Physician's Name & Address (include ZIP Code) **Physician's name** Justin Ray, MSN, PMHNP-BC **Street address** 200 Carmichael Way **Apt./Suite** 604 **City, State, Zip Code** Chesapeake, VA 23322	42. Telephone Number (757) 908-2124 44. Patient Account Number	43. 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. 47-3995278 45. Total charge $ _____ Amount paid $ _____ Balance due $ _____
46. Physician's or Supplier's Signature	47. National Provider Identifier 1093013641	48. Date