INSTRUCTIONS ON HOW TO COMPLETE AETNA INSURANCE CLAIM FORM

(There is an 800# on your insurance card you may call for further questions)

SECTION TO BE COMPLETED BY EMPLOYEE: Employee means the person responsible for paying the insurance. For example, if the Wife is the Patient and is covered under her Husband's health insurance plan, then the "Husband" is considered "The Employee."

SECTIONS 1-8 ARE ALL EMPLOYEE'S INFORMATION (Birthday, Address, Phone, etc.)

SECTIONS 9-17 ARE ALL PATIENT INFORMATION (Name, Marital Status, etc.)

SECTION 18 CLAIM RELATED TO AN ACCIDENT? Did the Patient suffer some sort of accident and now seeks medical/mental health services? For example, a patient was in a car accident and now seeking mental health services for Anxiety related to driving therefore, the answer to this question would be "YES." Otherwise, if patient's visit is NOT related to an accident, then the answer is "NO."

SECTION 19 CLAIM RELATED TO EMPLOYMENT? For example, the patient seeks medical/mental health services due to some sort of stress or issue at work (discrimination, harassment, etc.) the answer would be "YES." Otherwise, if patient's visit is NOT work related, then the answer is "NO."

SECTION 20 ANY OTHER MEMBER COVERAGE? This section is to be completed only if other medical coverage exists. If any other family member receives health benefits from someone other than Aetna (Medicare, Medicaid, etc.)

SECTION 21 If the answer to SECTION 20 is YES, then complete this section. The information is found on the person's insurance card (If Social Security Disability would be on Medicare card).

SECTIONS 22, 23, 24 This question continues to refer to "The Family Member" from Section 20. In the example given from above, this would be the Husband's ID number, his name and birthday.

SECTION 25 Requires Patient's signature

SECTION 26 As the Patient, **DO NOT** sign this section. Insurance Reimbursement is to go DIRECTLY to the patient (as stated on patient's office visit receipt). You may write in "NOT AUTHORIZIED"

SECTION 27 AND REMAINING SECTIONS TO BE COMPLETED BY HEALTH CARE PROVIDER

****BRING INSURANCE CLAIM FORM TO YOUR OFFICE VISIT (Patient section completed). HEALTH CARE PROVIDER WILL SIGN FORM IN ORDER FOR YOU TO SUBMIT YOUR CLAIM TO RECEIVE REIMBURSEMENT. MAILING ADDRESS REFER TO THE BACK OF YOUR ID CARD**