Medicare Reimbursement Form for Employer Group Medicare Members

Section 1: Member information *(print clearly)*

Aetna® member ID:

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

Phone number *(with area code):* – –

Last name:

First name:

Middle initial:

Email:

Street address:

City:

State:

ZIP code:

Section 2: Claim request *(information must match your itemized bill)*

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

Reimbursement type *(select one):*

❑ Hearing ❑ Vision ❑ Dental ❑ Fitness
❑ Medical ❑ Vaccine ❑ Wigs ❑ Other

Amount paid:

$, .

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

If Hearing, Vision, Dental, Medical, Vaccine, please complete Section 3. Otherwise, skip to Section 4.

Section 3: Doctor, dentist or health care provider

Individual or health care provider:

Provider NPI number
(national provider identifier — get this number from your provider):

Provider TIN number
(taxpayer identification number — get this number from your provider):

Street address:

City:

State:

ZIP code:

Phone number *(with area code):*

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Section 4: Point of sale transaction for items or services, for example, retailer *(Skip this section if you already filled out section 3.)*

Name of retailer, etc.:

Street address:

City:

State:

ZIP code:

Country:

Section 5: Signature

By signing and submitting this form, you are certifying that the information is true and correct and that the services or items for which you requested reimbursement are for your sole use. You are certifying that you understand that any person who knowingly files a claim containing any false or misleading information may be guilty of fraud and is subject to criminal or civil penalties.

_____

Aetna Member ID

_____ _____

Member Signature or Authorized Representative Signature **Date**

Section 6: Acknowledgment

Questions?

We are here to help. Just give us a call at **the number on your ID card 8AM–8PM, 7 days a week**.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. Plan features and availability may vary by service area.

Important disclaimers

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Reimbursement instructions

How to complete this Reimbursement Form

When to use this form

1. Fill out this form if you're asking for reimbursement of a covered service such as Hearing, Vision, Dental, Fitness, Medical, Vaccine, Wigs, or you paid a doctor, health care professional or a supplier of items and services who did not bill us directly. Please read below for additional information about types of vaccines.
2. Don't use this form for prescription drug claims or shingles, RSV, tetanus/diphtheria (Td), Tetanus, diphtheria and pertussis (whooping cough) (Tdap), Hepatitis A, Hepatitis B vaccine reimbursements. Visit **AetnaRetireePlans.com** or call the Member Services number on your member ID card for a prescription drug claim form.
3. Please fill out a separate form for each reimbursement type.

How to fill out this form

1. Complete each section. Print clearly in black ink only. Or you can also visit **AetnaMedicare.com/en/forms/member-reimbursement.html** to type the information in the form online.
2. Sign and date the bottom of the completed form. If you are filling this in on someone's else's behalf, there must be an appointed representatives form on file. This form can be found at **AetnaMedicare.com/groupmedicare/en/for-members/view-coverage-benefits.html?#permission**.

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. Submit a proof of payment. The proof of payment must clearly state what was purchased, when it was purchased, how much it cost and how it was paid for.
3. Mail this completed form and your original receipts and itemized bills to the address on your Aetna member ID card.
4. 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 of service or transaction.
2. Please complete all required information. If your request is incomplete, it will delay processing time. We will reach out to you or your provider for any missing information. If we cannot obtain the missing information, your claim will be denied.
3. If we approve your request, it can take up to 45 days to send payment once we have all the required information.