Medicare Reimbursement Form for Employer Group Medicare Members

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 dental, fitness, hearing, medical, certain vaccines, vision, wigs or other. You can also use this form if you paid a doctor, health care professional or supplier of items and services who did not bill us directly.
2. **Don't use this form** for prescription drug claims or for certain vaccine reimbursements, including shingles, RSV, tetanus/diphtheria (Td), tetanus, diphtheria and pertussis (whooping cough) (Tdap), hepatitis A or hepatitis B. Instead, 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. Make copies of all your receipts and itemized bills from your provider. Be sure to include your Aetna® member ID number on each receipt and bill. We will retain all materials submitted and cannot return them 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. Complete each section. Print clearly in black ink only. Or you can log in to **Health.Aetna.com/digital-claims** to submit the information online.
4. Sign and date the bottom of the completed form. If someone other than the member is signing the form, you must have an Appointment of Representative form on file with the health plan. You can find this form at **AetnaRetireePlans.com**.

Where to send the completed form

1. Mail this completed form and your original receipts and itemized bills (which you can get from your provider's office or retailer) to the address on your Aetna member ID card:
   Aetna Medicare
   PO Box 981106
   El Paso, TX 79998-1106
2. Or 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. **Important note:** Fitness DMR follows the submission date outlined in your Schedule of Cost Sharing (SOC).
2. You must provide all the requested information. If you don't, it may take longer for us to pay you back. Or we may not be able to pay you back at all.
3. Approved requests can take up to 45 days to send a check to the address we have on file.

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:

Street address:

City:

State:

ZIP code:

Email:

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

Reimbursement type *(select one):*

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

Date of Service or Purchase	Procedure Code (if applicable)	Description of Service or Item	Amount Paid	Diagnosis Code (if applicable)

If dental, hearing, medical, vaccine or vision, please complete Section 3. Otherwise, skip to Section 4.

Section 3: Doctor, dentist, health care provider or retailer

Individual, health care provider or retailer:

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):*

Section 4: Point-of-sale transaction for items or services (fitness, wigs or other, as noted above)

Name of provider or 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, 8 AM–8 PM, 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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