



Medical Benefits - Claim Instructions

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 daim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance ad, which is a crime and subjets such person to criminal and civil penalties.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent daim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subjed to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: My person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of daim containing any materially false information or conceals, for the purpose of misleading, information concerning any fad material thereto commits a fraudulent insurance ad, which is a crime and subjets such person to criminal and civil penalties.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading fads or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading fads or information to a policyholder or daimant for the purpose of defrauding or attempting to defraud the policyholder or daimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: My person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of daim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of daim containing any materially false information or conceals, for the purpose of misleading, information concerning any fad material thereto may have vitiated state law.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of daim containing any materially false information or conceals, for the purpose of misleading, information concerning any fad material thereto commits a fraudulent insurance ad, which is a crime and may subjed such person to criminal and civil penaties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of daim containing any false or misleading information is subjed to criminal and civil penalties.

Attention New York Residents: My person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of daim containing any materially false information, or conceals for the purpose of misleading, information concerning any fad material thereto, commits a fraudulent insurance ad, which is a crime, and shall be subjed to a civil penally not to exceed We thousand dollars and the stated value of the daim for each violation.

Attention North Carolina Residents: My 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 daim containing any materially false information or conceals, for the purpose of misleading, information concerning any fad material thereto commits a fraudulent insurance ad, which may be a crime and subjets such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: My person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any daim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of daim containing any materially false information or conceals for the purpose of misleading, information concerning any fad material thereto may have violated state law.

Attention Puerto Rico Residents: My person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent daim to obtain payment of a loss or other benefit, or files more than one daim for the same loss or damage, commits a felony and if found guilty shall be punished for each vitiation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating droumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating droumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: My 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 daim containing any materially false information or conceals, for the purpose of misleading, information concerning any fad material thereto commits a fraudulent insurance ad, which may be a crime and may subjed such person to criminal and civil penalties.

Attention Virginia Residents: 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 daim containing any materially false information or conceals, for the purpose of misleading, information concerning any fad material thereto commits a fraudulent ad, which is a crime and subjets such person to criminal and civil penaties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE EMPLOYEE

1. Complete items one (1) through twenty-two (22) in full.
2. Complete items 23-27 only if other medical coverage exists.
3. Be certain to sign the authorization to release information block (28).
4. If you wish to have your benefits for this daim paid directly to your physician or supplier, sign the block (29).
5. If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
6. Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:

- patient's name
- date(s) of service(s)
- condition being treated
- relationship to employee
- type of service(s) rendered

If this information is missing, write it on the bill and sign your name.

7. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:

- | | |
|-----------------------------|---------------------------|
| drug name | strength |
| dose per/day | prescription number |
| charge | quantity |
| purchase date | physician's name pharmacy |
| nature of illness or injury | name/address |

This information can be copied from the prescription bottle or box. Retain

8. copies of your bills for your record.
9. Refer to the back of your ID card for claim mailing address.

TO THE PHYSICIAN OR SUPPLIER

1. Complete items thirty (30) through forty-eight (49) in full.
2. If the employee indicates that benefits should be paid directly to the physician or supplier, then these benefits will be sent directly to you with an information copy of the transactions to the employee.



Medical Benefits Request

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

TO BE COMPLETED BY EMPLOYEE									
1. Employer's Name TD Banknorth					2. Policy/Group Number 818960				
3. Employee's Aetna ID Number			4. Employee's Name			5. Employee's Birthdate (MM/DD/YYYY)			
6. <input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement			7. Employee's Address (include zip code) <input type="checkbox"/> Address is new			8. Employee's Daytime Telephone Number ()			
9. Patients Name			10. Patients Aetna ID Number		11. Patient's Birthdate (MM/DD/YYYY)		12. Patients Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
13. Patients Address (if different from employee)			14. Patients Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	15. Full Time Student <input type="checkbox"/> No <input type="checkbox"/> Yes	16. Patient's Expected Graduation Date		17. Name of School City		
18. Patients Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single			19. Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes		20. Name & Address of Employer				
21. Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date							22. Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes		
23. Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross- Blue Shield, etc.), multiple auto insurance, Medicare or any federal, state or local government plan? <input type="checkbox"/> No <input type="checkbox"/> 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		
M. 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 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 Identif	Description of Service	Type of Service t	Charges	Days or Units	Diagnosis Code t t	Administrative Use Only	
42. Physician's Name & Address (include zip code)				43. Telephone Number ()		44. Enter the taxpayer identifying number to be used for reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.			
47. Physician's or supplier's signature				48. National Provider Identifier		49. Date			
45. Patient Account Number				M. Total charge \$		Amount paid \$		Balance due \$	

* Place of Service Codes:

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

tType of Service Codes:

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