# Medicare Medical Claim Reimbursement Form

## Member information *(print clearly)*

**Aetna member ID:**

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

❑ **Male** ❑ **Female** ❑ **Non-Binary/Other**

(If you prefer not to disclose, leave blank)

**Last name:** **First name:** **Middle initial:**

**Street address:** **City:**

**State:** **ZIP code:** **Phone number *(with area code):*** ___ – ___ – ___

## Doctor, health care professional or supplier information

**Provider or supplier name (individual practitioner name):**

**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):*** ___ – ___ – ___

## Claim request *(information must match your itemized bill)*

**Date of service *(MM/DD/YYYY):*** ___ / ___ / ___

**Amount paid:** $ ___ , ___ . ___

**Reimbursement type:**

❑ Medical ❑ Dental ❑ Eyewear ❑ Out-of-network fitness ❑ Vaccine ❑ Hearing aid ❑ Other

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

## Signature

By signing and submitting this form, you certify that the information is true and correct.

_____ _____

**Member or authorized representative signature** **Date**

## Acknowledgment

### Questions?

We're here to help. Just give us a call at **1-833-570-6670 (TTY:711) 8AM-8PM, 7 days a week**.

### 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.

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.



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# Reimbursement Instructions

## How to complete this Medical Claim Reimbursement Form

### When to use this form?

1. Fill out this form if you're asking for reimbursement of a covered a medical service, dental service, eyewear, hearing aid, vaccine or fitness reimbursement you paid a doctor, healthcare professional, or service provider who did not bill us directly.
2. Don't use this form for prescription drug claim reimbursements.
   Visit **AetnaMedicare.com** or call the member services number on your member ID card for a prescription drug claim form.

### How to fill out this form?

1. Complete each section. Print clearly in black ink only or type the information in the form online.
2. Sign and date the bottom of the completed form. Appointed representatives must have an Appointment of Representative form on file with the health plan, or you can submit one with this form. You can find an Appointment of Representative form on **AetnaMedicare.com.**

### 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. Mail this completed form and your original receipts and itemized bills to the medical claims address on your Aetna member ID card.
3. 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 you received the service or item.
2. If your request is incomplete, we will communicate to you on your monthly Explanation of Benefits and this will delay processing.
3. You must provide the name of the individual practitioner who performed the service.
4. If we approve your request, it can take up to 45 days to send payment once we have all the required information.