How to Complete this Medical Claim Form

Please complete this form properly and in its entirety. To avoid delays in processing, be sure to attach an original fully itemized bill(s) along with any supporting documentation.

1. The Member or Authorized Person must complete the following sections of the Benefit Claim Form:
    - Member
    - Patient Information
    - Accident Information
    - Medicare Information
    - Other Health Insurance
    - Authorization/Release of Information/Assignment of Benefits

2. Authorization/Release of Information

    Your signature authorizes the Plan to obtain information to carry out our processing of the claim(s).

3. Assignment of Benefits

    Your signature authorizes the Plan to pay the Provider or Supplier directly.

4. Submitting the Claim Form

    Please check with the Provider or Supplier to see if they will file the claim on your behalf, especially if MHBP is the secondary payer. Otherwise, you are responsible for the filing of the claim(s) with us.

    If you have an itemized bill, please attach and mail to the address on the claim form. If you need assistance with completing this form, please contact the Plan at 1-833-497-2416 **(TTY:** 711**)**.

MHBP | aetna Medical Claim Form

PO Box 981106
El Paso, TX 79998

Member Information *(please print)* - See Page 1 for instructions on how to complete this claim form.			
Last Name	First	MI	Member ID Number

Patient Information – Complete this section only if claim is for a qualified dependent.			
Last Name	First		MI
Patient ID	Date of Birth	Relationship	Gender

Accident Information – Complete this section only if claim is result of accident or work-related illness or injury.	
Date of accident or first symptoms of illness?	Where did the accident occur? (City/State)
Is accident/illness related to employment? If no, ☐ Auto ☐ Other	Describe the accident or illness.
Give date patient first consulted physician.	Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Medicare Information – Complete this section only if patient is eligible for Medicare.		
Please attach copy of the "Explanation of Benefits" statement from your Medicare insurance carrier.		
Medicare Number (include any alpha characters)	Effective Date (Part A)	Effective Date (Part B)

Other Health Insurance – If Yes, complete section below or claim cannot be processed. ☐ No other coverage			
Name of Policyholder	Policy Number		
Name of Insurance Company	Insurance Company Phone Number		
Street Address	City	State	ZIP

Authorization/Release of Information	
I authorize any insurance company, organization, employer, hospital physician, pharmacist, or other health care provider to release any information requested with regard to this claim and the expenses reported. I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to omit facts I know are important.	
Patient or authorized person's signature	Date

Assignment of Benefits	
I agree to assign benefits directly to the provider of services.	
Patient or authorized person's signature	Date

THIS SECTION FOR PHYSICIAN OR SUPPLIER ONLY.
If a detailed statement is available, please attach.

Provider Statement of Services Rendered

Name and address of facility where services were rendered (if other than home or office)	Date Admitted
	Date Discharged

Diagnosis Code and Description

1. 3.
2. 4.

Date of Service (from/to)	Place of Service	CPT-4 Procedure Code	Description of Service	Charges	Days or Units

Signature of Provider	Total Charge	Amount Paid	Balance Due
Provider Name	Tax ID Number		
Provider Address	Telephone Number ( )		

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude, or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation, or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 1-800-648-7817, TTY: 711,
Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697** (TDD).

(TTY: 711)

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.