Physician's Statement

Aetna Global Benefits®

Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

- ***This form should be completed and submitted if an itemized bill is not provided to accompany the Claim Form (GR-68069). The Summary of Reimbursement section of the Claim Form will identify the party to whom benefit payments should be made payable/sent.***
- Fully itemized bills and receipts should include: Patient's name and relationship to employee, Provider Name/address/telephone number, date of service, Amount charged, Diagnosis/nature of illness, and Procedures performed (office visit, lab, surgery, etc.).
- If fully itemized bills are not provided, Provider's should complete this form and attach it to all bills and a completed **Claim Form (GR-68069)**, and mail them to the address on the back of the member's insurance Identification Card or **Aetna Global Benefits, P.O. Box 30258, Tampa, FL 33630-3258, U.S.A.**

Patient Information (Type or Print)

1. Patient's Name (first, middle initial, last name)	2. Patient's Date of Birth *(mm/dd/yyyy)*	3. Employee's Name
4. Employee's Social Security/I.D. Number	5. Employee's Employer	Aetna Policy/Grp Number

Physician or Supplier Information (To be completed by physician and returned to employee if a completely itemized bill is not provided.)

6. Date of *(mm/dd/yyyy)* Illness (first symptom) or injury (accident) or pregnancy (LMP)	7. Date first consulted you for this condition *(mm/dd/yyyy)*	8. Has patient ever had same or similar symptoms? If "Yes", give dates *(mm/dd/yyyy)* ☐ Yes ☐ No	9. If an emergency check here ☐
10. Date patient able to return to work condition *(mm/dd/yyyy)*	11. Date of total disability from *(mm/dd/yyyy)* through *(mm/dd/yyyy)*	Date of partial disability from *(mm/dd/yyyy)* through *(mm/dd/yyyy)*	
12. Name of referring physician (e.g., Public Health Agency)		13. For services related to hospitalization give hospitalization dates admitted *(mm/dd/yyyy)* discharged *(mm/dd/yyyy)*	
14. Name & address of facility where services rendered (if other than home or office)		15. Was laboratory work performed outside your office? ☐ Yes ☐ No Charges: $	

16. Diagnosis or nature of illness or injury (please indicate primary and secondary)
1.
2.
3.

17. Date of Service *(mm/dd/yyyy)*	Place of Service*	Procedure Code Identify**	Description of Service	Type of Service ✝	Charges	Days or Units	Diagnosis Code ✝✝	Administrative Use Only

18. Physician's or Supplier's Name & Address (include zip code)	19. Telephone Number ( )	20. If applicable, enter the taxpayer identifying number to be used for U.S. 1099 reporting purposes. You are required under authority of U.S. law to furnish your taxpayer identifying number.
	21. Patient Account Number	22. Total Charge $ ________ Amount Paid $ ________ Balance Due $ ________
23. Physician's or Supplier's Signature		24. Date

* Place of Service Codes:

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

✝ Type of Service Codes:

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

**** Please Use Current Procedural Terminology Codes For Surgery ✝✝ Please Use ICD•9•CM For Discharge Diagnosis**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. **Attention California Residents:** For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties. **Attention Colorado Residents:** An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division. **Attnetion Pennsylvania Residents:** Any person who knowingly and with intent to defraud 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.

Please Retain A Copy For Your Records