



Hearing Aid Claim Form

Fax to: **Aetna**
Attn: Dee Hill
817-417-2636

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name		2. Policy Number 660751	
3. Employee's Aetna ID Number	4. Employee's Name		5. Employee's Birthdate (MM/DD/YYYY)
6. Employee's Address (include zip code) <input type="checkbox"/> Address is new		7. Employee's Daytime Telephone Number ()	
8. Patient's Name	9. Patient's Aetna ID Number	10. Patient's Birthdate (MM/DD/YYYY)	11. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
12. Patient's Address (if different from employee)		13. Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Full Time Student <input type="checkbox"/> No <input type="checkbox"/> Yes
15. Patient's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	16. Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes		17. Name & Address of Employer
18. Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm			19. Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes
20. Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross- Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? <input type="checkbox"/> No <input type="checkbox"/> Yes			
21. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:			
22. Member's ID Number	23. Member's Name		24. Member's Birthdate (MM/DD/YYYY)
25. 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 _____			
26. 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

27. Date of illness (first symptom) or injury (accident) or pregnancy (LMP)		28. Date first consulted you for this condition		29. If patient has had similar illness or injury, give dates				
30. Name of referring physician (e.g., Public Health Agency)								
31. Name & address of facility where services rendered (if other than home or office)								
32. Diagnosis or nature of illness or injury (please indicate primary and secondary) 1. 2. 3. 4.								
33. Procedures, Medical Services, Supplies Furnished								
Date of Service	Place of Service	Procedure Code Identify	Description of Service	Type of Service	Charges	Days or Units	Diagnosis Code	Administrative Use Only
	O	V2598	Hearing Aid	A		1	389.9	
34. Costco Purchase Agreement Number			35. Telephone Number ()		36. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number. 911223280			
37. Physician's Name & Address (include zip code) Costco Hearing Aid Center 999 Lake Drive Issaquah, WA 98027			38. Patient Account Number		40. Total charge \$ _____ Amount paid \$ _____ Balance due \$ _____			
			39. National Provider Identifier					
41. Physician's or Supplier's Signature				42. Date				