Medical Payment Plan – Hospital only

There are two options to file a claim:

Paper Submission:

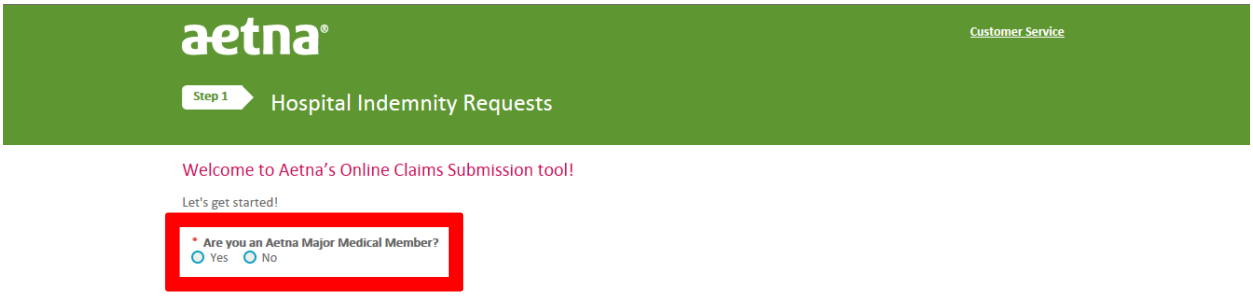
1. Print the Medical Payment Plan claim form found here: http://www.aetna.com/docfind/cms/assets/pdf/aahc/Medical%20Benefits%20Request%20(Generic).pdf . You can also get the form by calling us toll-free at **1-800-508-4015** or by writing to the Claims Department address below.

2. Locate your itemized hospital bill or UBO4 form received from the hospital. Please make sure that the hospital bill includes:
   - Date admitted
   - Date released
   - Diagnosis code

3. Please send the completed medical claim form and itemized bill or UBO4 to:
   Aetna Voluntary
   Claims Department
   P.O. Box 14079
   Lexington, KY 40512
   Or fax to **859-455-8650**

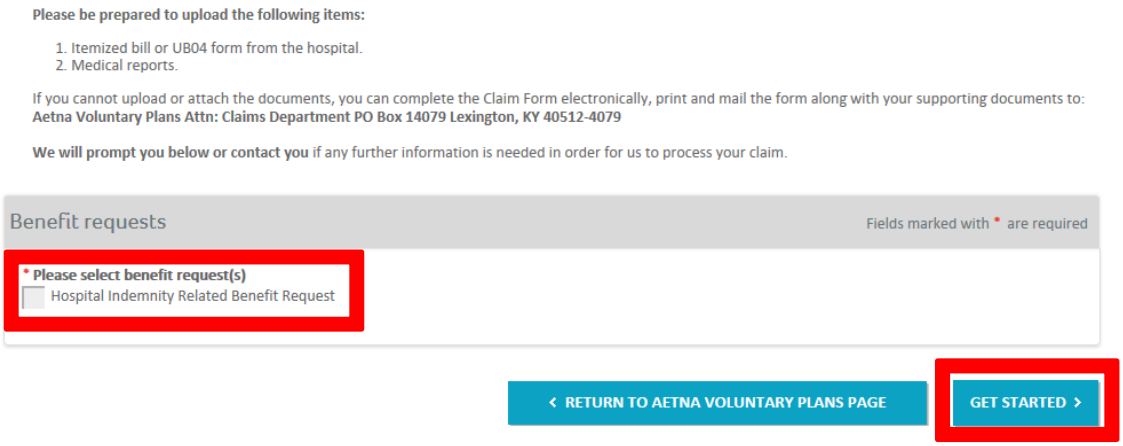
Electronic Submission:

1. Go to https://www12.aetna.com/AVOnlineClaimForm/welcome.aspx?productType=HOS to access the online claims submission tool.
2. Click "No" if you are not an Aetna Major Medical Member.



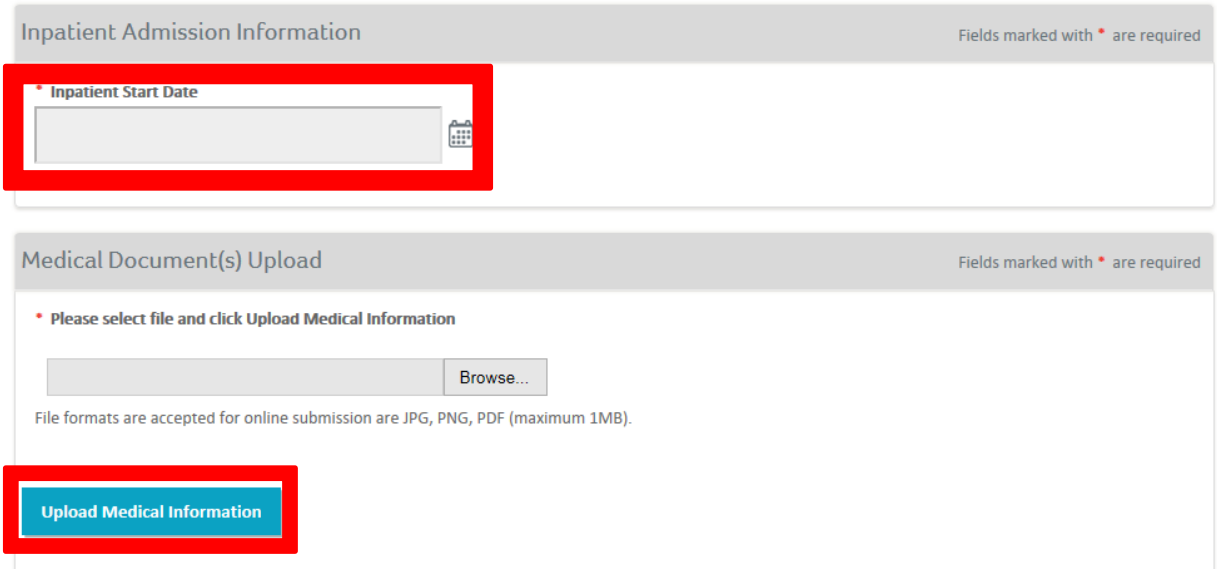
3. Please be prepared to upload the following items:
   1. Itemized bill or UB04 form from the hospital.
   2. Medical reports.

4. Click on “Hospital Indemnity Related Benefit Request” and “GET STARTED”

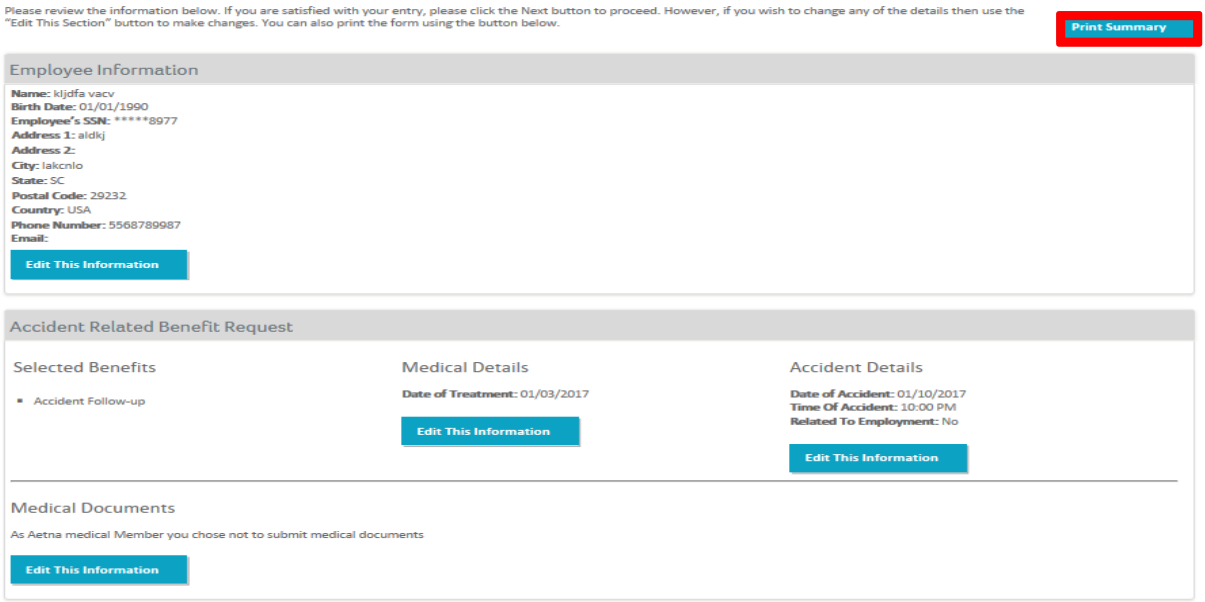


5. Enter the associate’s personal information (i.e. first name, last name, date of birth, daytime phone, and associates’s social security number), associates’s address information (address 1, city, state and postal code).
6. Enter the patient’s information (i.e. what is the relationship of the policy holder to the patient? If the patient is the policy holder, click self. If the patient is the spouse of the policy holder, click spouse etc). Then click next.

7. Provide the person’s information that is completing the online submission (full name, address, city, state and postal code). Complete the “Inpatient Admission Information” by adding the date the patient was admitted into the hospital and Upload the medical documents you have from the Hospital (UB04 or itemized hospital bill).



8. Click next
9. Please review the Benefit Request Summary to ensure all information is correct. You can print this summary page by clicking on "Print Summary".



10. Complete the Authorization and Misrepresentation Acknowledgment by typing your name and checking the acknowledgment. Then click submit.

Authorization to Release Information

Fields marked with * are required

Date: 1/10/2017

*** Patient signature**

Misrepresentation Acknowledgment

Fields marked with * are required

*** Please read and accept misrepresentation acknowledgment below.**

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 9% on the total amount payable or the face amount if payments are to made in installments until the total payment or the first installment is paid.

FRAUD WARNINGS BY STATE

NOTICE IN ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

☐ have read the misrepresentation acknowledgment

‹ Back Submit ›