

## Medical Payment Plan – Hospital only

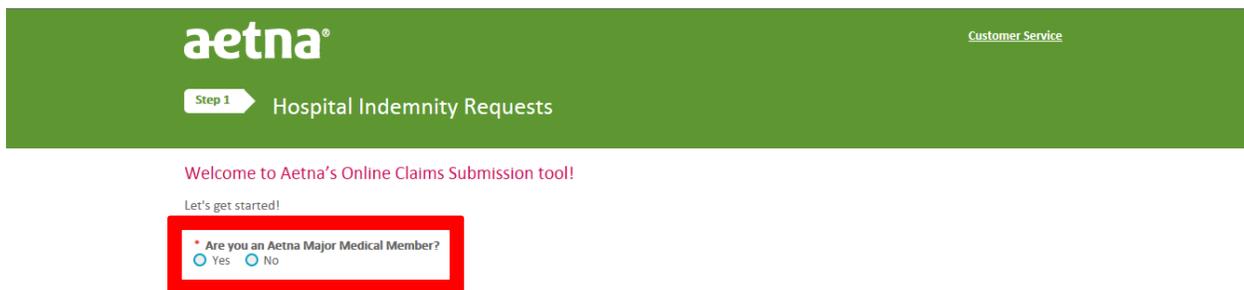
There are two options to file a claim:

### 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](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.



The screenshot shows the Aetna logo in the top left corner and "Customer Service" in the top right corner. Below the logo is a navigation bar with "Step 1" and "Hospital Indemnity Requests". The main content area displays a welcome message: "Welcome to Aetna's Online Claims Submission tool!" followed by "Let's get started!". A red-bordered box highlights a question: "Are you an Aetna Major Medical Member?" with radio button options for "Yes" and "No".

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"

Please be prepared to upload the following items:

1. Itemized bill or UB04 form from the hospital.
2. Medical reports.

If you cannot upload or attach the documents, you can complete the Claim Form electronically, print and mail the form along with your supporting documents to: Aetna Voluntary Plans Attn: Claims Department PO Box 14079 Lexington, KY 40512-4079

We will prompt you below or contact you if any further information is needed in order for us to process your claim.

Benefit requests Fields marked with \* are required

**\* Please select benefit request(s)**

Hospital Indemnity Related Benefit Request

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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.

Patient's Information Fields marked with \* are required

**\* Patient's relationship to policy/certificate holder**

Self  Spouse  Child  Other

[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).

## Inpatient Admission Information

Fields marked with \* are required

\* Inpatient Start Date



## Medical Document(s) Upload

Fields marked with \* are required

\* Please select file and click Upload Medical Information

Browse...

File formats are accepted for online submission are JPG, PNG, PDF (maximum 1MB).

Upload Medical Information

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".

Please review the information below. If you are satisfied with your entry, please click the Next button to proceed. However, if you wish to change any of the details then use the "Edit This Section" button to make changes. You can also print the form using the button below.

Print Summary

### Employee Information

Name: kjdifa vacv  
Birth Date: 01/01/1990  
Employee's SSN: \*\*\*\*\*8977  
Address 1: aldkj  
Address 2:  
City: lakcnlo  
State: SC  
Postal Code: 29232  
Country: USA  
Phone Number: 5568789987  
Email:

Edit This Information

### Accident Related Benefit Request

#### Selected Benefits

- \* Accident Follow-up

#### Medical Details

Date of Treatment: 01/03/2017

Edit This Information

#### Accident Details

Date of Accident: 01/10/2017  
Time Of Accident: 10:00 PM  
Related To Employment: No

Edit This Information

### Medical Documents

As Aetna medical Member you chose not to submit medical documents

Edit This Information

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.

I have read the misrepresentation acknowledgment

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Submit >