Attached are a couple of slides from our town hall meeting with the information to file claims with Aetna. Additionally, here a list of questions you can ask Aetna in regards to your out of network benefits. Included is the link for the claim form.
Feel free to contact us with any questions.

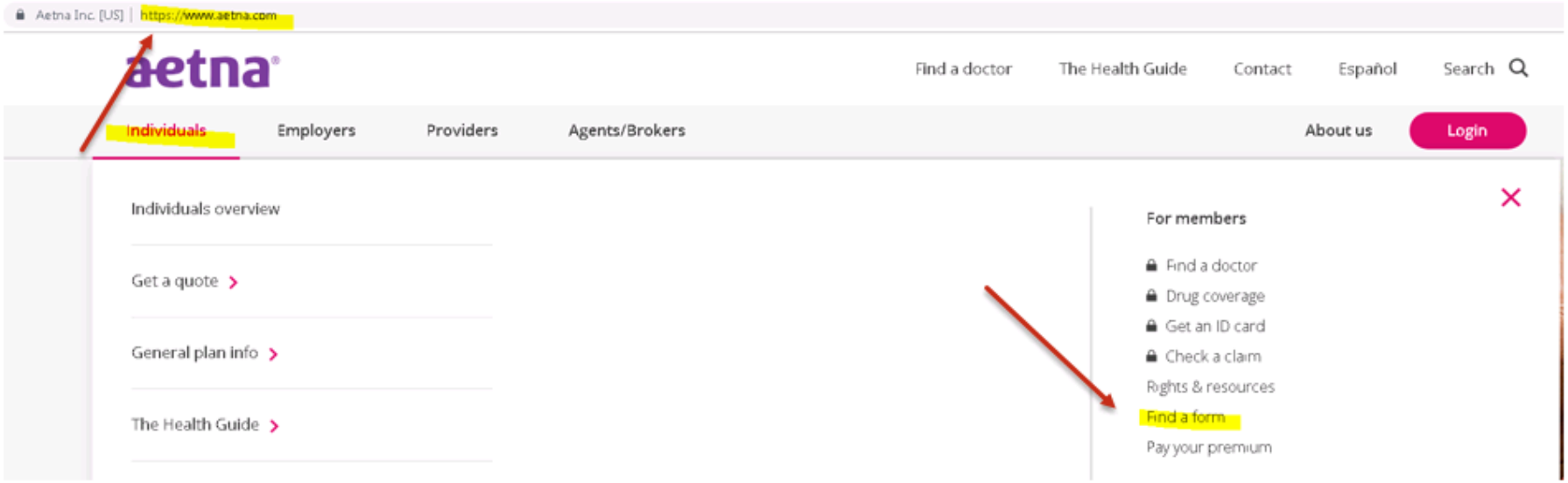
Questions to ask member services for out of network benefits:

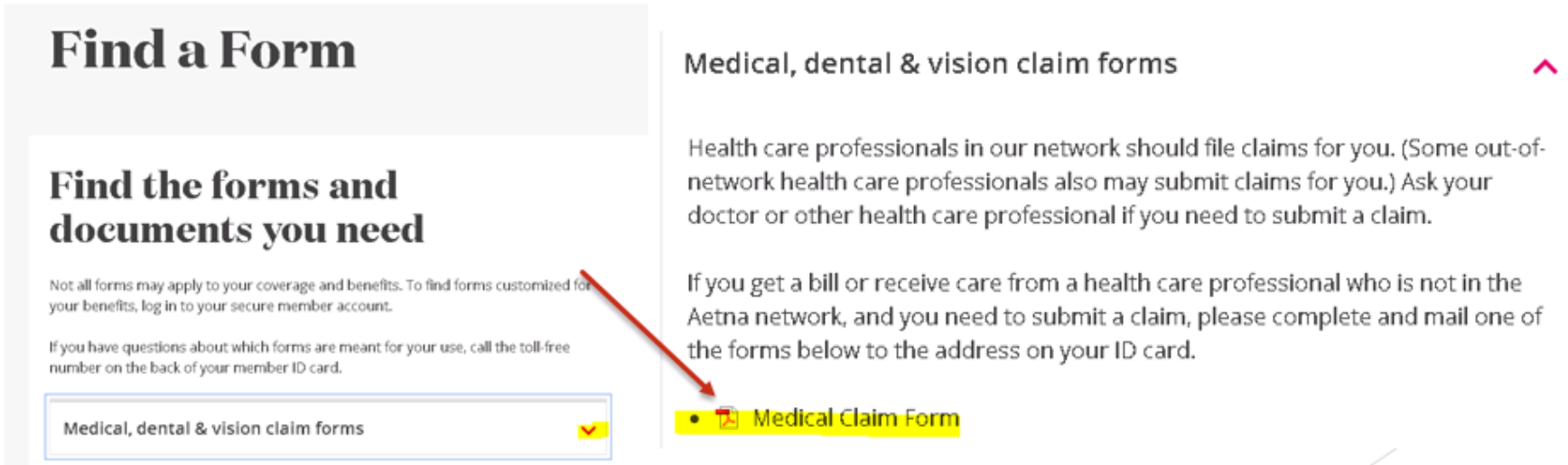
1. Do I have out of network benefits?
    a. If the answer in no, then ask if there is any way you could get reimbursed for services performed outside of the network (sometimes there might be exceptions).
    b. If the answer is yes to the question about out of network benefits, proceed with the following questions.
2. I would like get information about my coverage for out of network chiropractic services done in the office. Would you be able to help?
3. Is there a deductible to meet? If so, what is the deductible?
4. After I meet my deductible, is there a co-insurance?
5. Does my in-network deductible also apply to my out of network deductible?
6. Do I have an out of network out of pocket(OOP)?
7. Is this combined with my in-network OOP?
8. What is the reasonable and customary rate for my chiropractic services?
    a. They will probably need the following:
        i. TAX ID, NPI, CPT codes and ICD 10 codes.
    b. The specific information can be found on your services rendered receipt as well.
    c. Members services might also have this information from previous claims.
9. Is there a visit limit?
10. Are my visit limits based on medical necessity?
11. Are there any other limitations to chiropractic services?
12. How do I file a claim?
13. Is there a time limit for filing claims?
14. How soon can I expect a payment or explanation of benefits?

http://www.aetna.com/individuals-families-health-insurance/document-library/medical-claim-form.pdf

Out of Network Claims Aetna

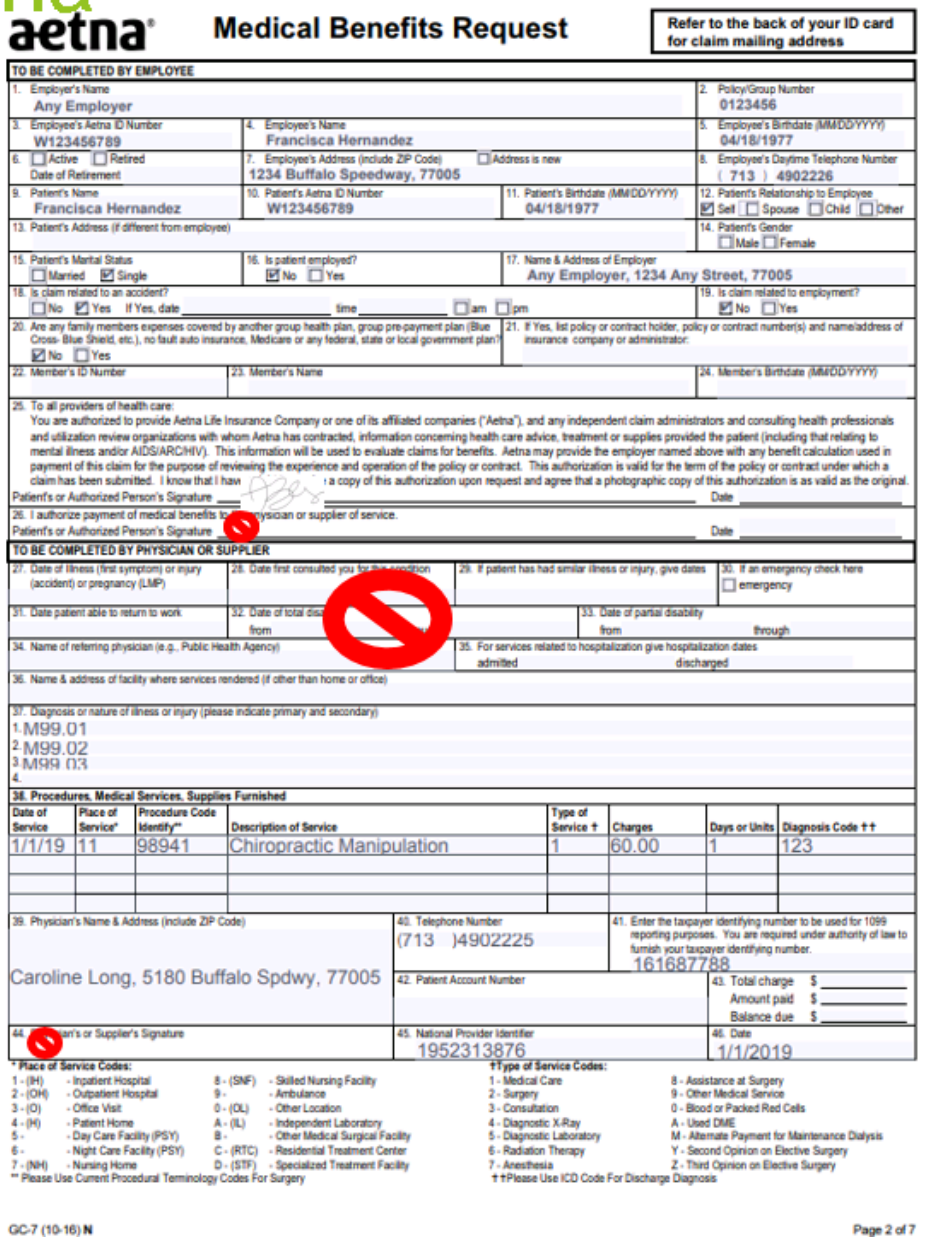
- If you don't have an existing account with Aetna, go to aetna.com. Then click on the INDIVIDUALS icon. Then click on the FIND A FORM link.
- Once on the forms page, click on the Medical, dental & visions claim forms drop down box.
- Then select Medical Claim Form.





Out of Network Claims Aetna

- The second page is your claim form.
- The top section is your information. Fill in your Member ID, Group number, Birthdate, Gender, Patient, and Policyholder information.
- The accident and other insurance information only needs to be filled out if you've been in an accident and/or have other coverage.
- BE SURE to sign and date your form.
- DO NOT sign the Assignment of Benefits. Your payment will not be sent to you.
- No Need to fill in this section.
- This section is information about your visit. We can give you this information. It's also available on your Services Rendered Statement.
- This part of the form is the providers information. It can also be found on your Services Rendered Statement.
- Send this form along with the Services Rendered Statement we give you.



aetna® **Medical Benefits Request**

Refer to the back of your ID card for claim mailing address

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name: Any Employer		2. Policy/Group Number: 0123456
3. Employee's Aetna ID Number: W123456789	4. Employee's Name: Francisca Hernandez	5. Employee's Birthdate (MM/DD/YYYY): 04/18/1977
6. ☐ Active ☐ Retired Date of Retirement	7. Employee's Address (include ZIP Code) ☐ Address is new: 1234 Buffalo Speedway, 77005	8. Employee's Daytime Telephone Number: (713) 4902226
9. Patient's Name: Francisca Hernandez	10. Patient's Aetna ID Number: W123456789 / 11. Patient's Birthdate (MM/DD/YYYY): 04/18/1977	12. Patient's Relationship to Employee: ☑ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)		14. Patient's Gender: ☐ Male ☐ Female
15. Patient's Marital Status: ☐ Married ☑ Single	16. Is patient employed? ☑ No ☐ Yes / 17. Name & Address of Employer: Any Employer, 1234 Any Street, 77005	
18. Is claim related to an accident? ☐ No ☑ Yes If Yes, date ____ time ____ ☐ am ☐ pm		19. Is claim related to employment? ☑ No ☐ 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? ☑ No ☐ 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 hav … 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 … ysician 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. If an emergency check here ☐ emergency
31. Date patient able to return to work	32. Date of total dis… from	33. Date of partial disability from ____ through ____	
34. Name of referring physician (e.g., Public Health Agency)		35. For services related to hospitalization give hospitalization dates admitted ____ discharged ____	
36. Name & address of facility where services rendered (if other than home or office)			

37. Diagnosis or nature of illness or injury (please indicate primary and secondary)
1 M99.01
2 M99.02
3 M99.03
4

38. 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 ††
1/1/19	11	98941	Chiropractic Manipulation	1	60.00	1	123

39. Physician's Name & Address (include ZIP Code): Caroline Long, 5180 Buffalo Spdwy, 77005	40. Telephone Number: (713)4902225	41. 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: 161687788
	42. Patient Account Number	43. Total charge $ ____ Amount paid $ ____ Balance due $ ____
44. …an's or Supplier's Signature	45. National Provider Identifier: 1952313876	46. Date: 1/1/2019

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

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

** Please Use Current Procedural Terminology Codes For Surgery
†† Please Use ICD Code For Discharge Diagnosis

GC-7 (10-16) N

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