# Cox Medical Plan
# Medical Benefits Request Form

**Instructions:** *Incomplete forms will delay payment.* Complete all sections. To have benefits paid directly to your doctor, sign under "Assignment." If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to that plan and the explanation of benefits you received from that plan. Attach itemized bills or ask your health care provider to complete the applicable section on page 2. The bills must include: (1) the patient's name; (2) patient's relationship to the employee (3) the date of service (4) the condition being treated and (5) the type of service rendered.

| | | |
|---|---|---|
| Employer Name: **COX ENTERPRISES, INC.** | | Policy/Group Number: **779409** |
| Employee name: | Employee's ID Number*: | Birthdate (MM/DD/YYYY) |
| Address (include zip code) ☐ Address is new | Daytime telephone | ☐ Active ☐ Retired<br>Date of Retirement: |

**PATIENT INFORMATION**

| | | |
|---|---|---|
| Patient's Name: | Patient's ID Number*: | Birthdate (MM/DD/YYYY) |
| Address (if different from employee) | | Relationship to employee<br>☐ Self ☐ Spouse ☐ Child ☐ Other |
| Sex<br>☐ Male ☐ Female | Marital status<br>☐ Married ☐ Single | Is patient employed?<br>☐ No ☐ Yes Date of Retirement: |
| Employer's name and address: | | |

**OTHER COVERAGE INFORMATION**

Are any family members' expenses covered by another health plan, group pre-payment plan (Blue Cross/Shield, etc.), Medicare or any federal, state or local government plan ☐No ☐ Yes

If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:

| | | |
|---|---|---|
| Member's Name | Member's ID Number*: | Member's Birthdate (MM/DD/YYYY) |

**CLAIM INFORMATION**

| | |
|---|---|
| If claim is for laboratory test or doctor's office visit, state diagnosis or nature of illness. | Is claim related to employment?<br>☐ No ☐ Yes |

Is claim related to an accident?
☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm

Description of Accident:

☐ **PREVENTIVE CARE CLAIM**: By marking this box, I request these preventive care expenses be reimbursed from my preventive care benefit for either me or my covered spouse. Signature _____ Date _____

**RELEASE**

**To all providers of healthcare:** 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 _____

**ASSIGNMENT**

I authorize payment of medical benefits to the physician or supplier of service.

Patient's or Authorized Person's Signature _____ Date _____

**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 the claim was provided by the applicant. **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, may be subject to fines, confinement in state prison and may be liable for substantial civil penalties. Many other states have similar laws. **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. **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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

* For ID Number, please enter the Aetna member ID number listed on the indicated person's medical ID card.

**Send the completed benefits request and the bills to:**
Aetna Claim Office, PO Box 14079, Lexington, KY 40512 or FAX 1-859-455-8650
**Claim Questions?** Call toll free 1-888-553-3449

# Provider's Statement

| Employee's name: |
|---|
| Employee's ID Number*: |

| Patient's Name | Patient's Birthdate (MM/DD/YYYY) |
|---|---|

| Date of illness (first symptom), injury (accident) or pregnancy (LMP) | Date first consulted for this condition | If patient has had similar illness or injury, give dates: | If an emergency check here: ☐ Emergency |
|---|---|---|---|
| Date patient able to return to work | Date of total disability From Through | Date of partial disability From Through | |
| Name of referring physician (e.g., Public Health Agency) | For services related to hospitalization give hospitalization dates Admitted Discharged | | |
| Name & address of facility where services rendered (if other than home or office): | | | |
| Diagnosis or nature of illness or injury (please indicate primary and secondary)<br>1.<br>2.<br>3.<br>4. | | | |

**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 |
|---|---|---|---|---|---|---|---|---|
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| Physician's name: | Telephone: |
|---|---|
| Address: | Patient account number: |
| Taxpayer ID number (for 1099 reporting purposes – required by law): | Total Charge $ |
| | Amount paid $ |
| | Balance due: $ |
| Physician's or supplier's signature | Date |

**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
10 - (OL) Other Location
A - (IL) Independent Laboratory
B - Other Medical Surgical Facility
C - (RTC) Residential Treatment Center
D - (STF) Specialized Treatment Facility

**** Please Use Current Procedural Terminology Codes For Surgery Diagnosis**

**+Type of Service Codes:**

1 –Medical Care
2 – Surgery
3 – Consultation
4 – Diagnostic X-Ray
5 – Diagnostic
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 ICD•9•CM For Discharge**

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