

Any person who knowingly and with intent to injure, defraud or deceive 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Alabama Residents: 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. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents:** For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive 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 thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. **Attention New York 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 thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Patient/Member Signature

Date

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE ALLINA HEALTH | AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE EMPLOYEE

- Complete items one (1) through nineteen (19) in full.
- Complete items twenty (20) through twenty-four (24) only if other medical coverage exists.
- Be certain to sign the authorization to release information in block twenty-five (25).
- If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block twenty-six (26).
- If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
- Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:
 - patient's name
 - condition being treated
 - type of service(s) rendered
 - date(s) of service(s)
 - relationship to employee
 If this information is missing, write it on the bill and sign your name.
- If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:
 - drug name
 - purchase date
 - prescription number
 - pharmacy name/address
 - dose per/day
 - nature of illness or injury
 - quantity
 - charge
 - strength
 - physician's name
 This information can be copied from the prescription bottle or box.
- Retain copies of your bills for your record.
- (Misrepresentation): NY residents please sign and date
- 10. Refer to the back of your ID card for claim mailing address.**

TO THE PHYSICIAN OR SUPPLIER

- Complete items twenty-seven (27) through forty-six (46) in full.
- If the employee indicates that benefits should be paid directly to the physician or supplier, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

TO BE COMPLETED BY EMPLOYEE

| | | | |
|--|--|--|---|
| 1. Employer's Name | | 2. Policy/Group Number | |
| 3. Employee's ID Number | 4. Employee's Name | | 5. Employee's Birthdate (MM/DD/YYYY) |
| 6. <input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement | 7. Employee's Address (include ZIP Code) <input type="checkbox"/> Address is new | | 8. Employee's Daytime Telephone Number () |
| 9. Patient's Name | 10. Patient's ID Number | 11. Patient's Birthdate (MM/DD/YYYY) | 12. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |
| 13. Patient's Address (if different from employee) | | | 14. Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 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 Allina Health and Aetna Insurance Company (Allina Health Aetna), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Allina Health 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. Allina Health 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. If an emergency check here <input type="checkbox"/> emergency | |
|---|-------------------|--|------------------------|---|---------|--|-------------------|
| 31. Date patient able to return to work | | 32. Date of total disability from _____ through _____ | | 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. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 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 †† |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 39. Physician's Name & Address (include ZIP Code) | | | | 40. Telephone Number () | | 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. | |
| 44. Physician's or Supplier's Signature | | | | 42. Patient Account Number | | 43. Total charge \$ _____ | |
| | | | | | | Amount paid \$ _____ | |
| | | | | | | Balance due \$ _____ | |
| 45. National Provider Identifier | | | | 46. Date | | | |

* Place of Service Codes:

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

** Please Use Current Procedural Terminology Codes For Surgery

† Type of Service Codes:

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

† † Please Use ICD Code For Discharge Diagnosis

Allina Health | Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: **711**,
Fax: **859-425-3379**, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019**, **800-537-7697** (TDD).

Health plans are offered, underwritten or administered by Allina Health and Aetna Insurance Company (Allina Health | Aetna). Allina Health | Aetna is an affiliate of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Allina Health | Aetna. Allina Health | Aetna has sole financial responsibility for its own products.

TTY:711

| | |
|----------------------|--|
| English | To access language services at no cost to you, call the number on your ID card. |
| Spanish | Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación. |
| Hmong | Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID. |
| Cushitic-Oromo | Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili. |
| Vietnamese | Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị. |
| Chinese Traditional | 如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼 |
| Russian | Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте. |
| Lao | ເພື່ອໃຊ້ບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ. |
| Amharic | የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎች ላይ ያለውን ቁጥር ይደውሉ፡፡ |
| Karen | လ၌တၢကမ္ဗူကျိၣ်တၢမၤစ၌အတၢဖံးတၢမၤတဖၣ် လ၌တအိၣ်ဒီးအပူလ၌နကဘၣ်ဟ့ၣ်အိၣ်အိၣ်ကိးဘၣ်လိတဲစိနီၣ်ကံၤလ၌အိၣ်လ၌နခိၣ်ဂီၤ ၁ (၅) အလိၣ်တက့ၢ်ၣ် |
| German | Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. |
| Mon-Khmer, Cambodian | ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។ |
| Arabic | للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك. |
| French | Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé. |
| Korean | 무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. |
| Tagalog | Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card. |

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