

Weight Management / Smoking Cessation Claim Form

Submit to: Aetna. • P.O. Box 981107 • El Paso, TX 79998-1107 • (800) 544-5108 • Fax: (859) 455-8650

Name _____ Member ID # _____

Address _____ City _____ State _____ Zip Code _____

Work Telephone Number _____

This request is for reimbursement of (check one only): **WEIGHT MANAGEMENT EXPENSES**

SMOKING CESSATION EXPENSES

LIST OF EXPENSES

If an expense is covered under another medical plan; an “Explanation of Benefits” (EOB) form must be attached. If not covered, attach an itemized statement indicating the date of service.

Claimant Name	Relationship to Employee	Date of Service	Provider Name or Type of Service	Amount Charged
Total Reimbursement Requested				\$

I certify that to the best of my knowledge the expenses listed above have been incurred by me and/or my eligible dependent and will not be reimbursed by any other health benefit plan. I certify this is an eligible expense, as defined in the Summary Plan Description.

If I receive reimbursement for an ineligible expense, I agree to indemnify, hold harmless, and reimburse my employer or its agents for any penalty which may be imposed on any of them resulting from such receipt.

Any person who knowingly files a statement of claim containing any false, incomplete or misleading information with intent to defraud or deceive may be guilty of a criminal act punishable under law.

Employee Signature _____ **Date** _____

PLEASE NOTE: INCOMPLETE CLAIM SUBMISSION MAY RESULT IN A DELAY IN CLAIM PROCESSING AND MAY CAUSE YOUR CLAIM TO BE RETURNED TO YOU. PLEASE BE SURE TO INCLUDE ALL NECESSARY INFORMATION AND BE SURE YOUR CLAIM FORM IS SIGNED AND DATED.

1. Reimbursements are made based on the date of service, as services are rendered or after completion of the program. For example, you begin a program November 1, 2005 and make full payment for the program of \$300. (\$50 per month for six months) At the end of January you may submit the charge(s) incurred for January (\$50) or you may wait until the completion of the program and submit for charges incurred January through April (\$200).
2. When submitting a request for reimbursement remember that the analyst needs an itemized statement or bill showing a breakdown of the charges along with the date the services were incurred. A receipt that only shows a total charge does not provide the information needed to reimburse you.
3. Always complete the Weight Management / Smoking Cessation Claim Form. Do not leave any sections blank that should be filled in. The List of Expenses section is particularly important since you are providing the analyst with the information he/she needs to process your claim. You must sign and date the form in order for your claim to be processed.
4. If an expense is covered under any other group medical, an "Explanation of Benefits" (EOB) form from each of the coverage's must be attached to the completed claim form in order for your claim to be processed.
5. Remember that eligible expenses are those incurred in the plan year in which you are participating.
6. Reimbursement of expenses will be made to the participant upon submission of charge and proof of payment. Payment will only be made to the provider if they submit a claim on your behalf.