ExxonMobil Medicare Supplement Plan Claim Form

MAIL CLAIMS TO:
AETNA
P.O. BOX 14586
LEXINGTON, KY 40512-4586

GROUP # 660616

PHONE INQUIRIES:
TOLL FREE: 1-800-222-3992

HOW TO COMPLETE THIS FORM

A. This section relates to information about the **covered person**.
- Provide the name, Member ID number or Social Security number, address and phone number of the covered person.
- Indicate which type of covered person you are.
- You are the covered person if:
  - You are a retiree eligible for Medicare, or
  - You are the retiree whose spouse is eligible for Medicare, or
  - You are the survivor of a deceased employee or retiree and are eligible for Medicare, or
  - You are a COBRA participant in the ExxonMobil Medicare Supplemental Plan.

B. This section relates to information about the **patient**.
- Provide the patient's name, relationship to the covered person, Member ID number or Social Security number, sex and date of birth.

C. This section must be completed.

D. Your signature is required to complete this form.
1. In all cases, the patient or authorized person must sign.
2. If payment is to be made DIRECTLY to the service provider (such as a doctor or hospital), also sign this block.

HOW TO FILE A CLAIM

Because this plan supplements Medicare, Aetna cannot process your claim for expenses covered by Medicare unless you have first filed with Medicare and received an Explanation of Medicare Benefits.

In order to file a claim:
- Submit a separate claim form for each eligible family member. Multiple bills for each family member can be submitted with one claim form.
- Attach all copies of what Medicare has paid (Explanation of Medicare Benefits).
- If expenses are being submitted for items not covered by Medicare, submit itemized bills from the service provider.

When you have all the information necessary, mail your claim to the Aetna office shown on the top of this form.
BE SURE TO KEEP COPIES OF CLAIMS SUBMITTED FOR YOUR FILES.

A. Covered Person

NAME

MEMBER ID NUMBER OR SOCIAL SECURITY NUMBER

☐ RETIREE ☐ COBRA
☐ SURVIVOR OF A DECEASED EMPLOYEE OR RETIREE

STREET CITY STATE ZIP CODE PHONE NO.

B. Patient

NAME

☐ SELF ☐ SPOUSE ☐ CHILD

MEMBER ID NUMBER OR SOCIAL SECURITY NUMBER

☐ MALE ☐ FEMALE

BIRTHDATE

C.

Is the person for whom this claim is being filed covered under any group plan other than Medicare or the ExxonMobil Medicare Supplemental Plan?
If yes, give name and address and identification number of other plan.

☐ Yes ☐ No

D.

Patient Must Sign Below in All Cases

1). Authorization to Release Information:
I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or service. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____
Patient or Authorized Person Date

Sign Below Only if Payment Is to Be Made Directly to the Service Provider

2). Authorization to pay benefits to the service providers:
I hereby authorize payment of benefits directly to any service providers otherwise payable to me for services but not to exceed the reasonable and customary charge for those services.

I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Patient or Authorized Person Date

Information on Filing ExxonMobil Medicare Supplement Plan Claims

When to File a Claim

If you do NOT participate in the Medicare Direct program, you will have to file a claim with Aetna for reimbursement under the plan. Since this plan supplements Medicare, you must include a copy of the Explanation of Medicare Benefits statement with your claim form.

How to File a Claim

Here's what to remember when you file a claim:

- **Complete a claim form for each covered family member** who has received medical treatment. Provide all the information requested.
- **Attach the Explanation of Medicare Benefits statement.**
- **Remember to sign the form.**
- **Sign the Assignment section** if you want benefits to be paid directly to your provider.
- **Attach an itemized bill** to your claim form. Make sure that it includes:
  - Patient's name.
  - Patient's relationship to the participant (for example, self, husband, daughter). If this isn't shown, write it on the bill.
  - Patient's date of birth. If this isn't shown, write it on the bill.
  - Date of services.
  - Procedure codes.
  - Cost of each service or supply.
  - Provider's name, address and tax identification number (TIN).
- ***Mail*** your completed claim form, with itemized bill(s) attached, to:

  Aetna
  P.O. Box 14586
  Lexington, KY 40512-4586

Visit Us On-Line at www.aetna.com

When you visit the Aetna website, you'll find fast, up-to-date information about our company and a variety of health-related topics through:

- **Aetna InteliHealth℠,** for information on a variety of health topics, along with wellness and fitness tips.
- **Aetna Navigator®**, your source for personalized health information and convenient self-service functions.

With **www.aetna.com**, you have convenient access to help, information and services from the comfort of your home, day or night.

Understanding the Explanation of Benefits

You'll receive an Explanation of Benefits (EOB) each time a claim is processed. The EOB contains important information about how your claim was processed and what benefits were paid.

The circled numbers on the sample EOB correspond to the numbers in the following explanation:

1. Name and mailing address for the member.

2. Contact information to use for any questions.

3. Displays date Aetna received the claim.

4. First and last name of patient with middle initial.

5. Relationship of patient to the member.

6. First and last name of member.

7. The name of the plan sponsor.

8. The control, suffix, account, plan summary and unique plan identifiers.

9. The provider name, month, day and year the service was provided, and brief description of the service.

10. The amount billed for this service.

11. The amount being pended (i.e., placed on hold until additional information requested from the provider and/or member has been received and reviewed) or denied.

12. Remarks column displays a remark code that corresponds to the remark text shown in field 21.

13. Amount applied to deductible for the charges submitted.

14. The amount of the submitted bill, less any discount, amounts not covered or pending, copays and deductibles.

15. The percentage the plan will pay on the amount remaining of the submitted bill.

16. The amount the plan will pay for this service.

17. Also known as "Coinsurance". The portion of the allowable charges for which the member is responsible.

18. Indicates the total amount for which the patient is responsible. This includes copays, deductibles, coinsurance and not covered amounts.

19. The amount paid by your primary plan (Medicare).

20. Total for which the member is responsible.

21. Remarks section explains why a charge was not covered or a claim was pended.

22. Summary of plan financial limits for the benefit year such as deductible and lifetime maximum.

Aetna

P.O. BOX 14586
LEXINGTON, KY 40512-4586

EXPLANATION OF BENEFITS

Please Retain for Future Reference
Date Printed: 05/17/03
Page 1 of 1

THIS IS NOT A BILL

JOHN DOE
1000 MIDDLE STREET
MIDDLETOWN CT 06457

QUESTIONS? Contact us at **aetnanavigator.com**
For Customer Service please call: 1-800-222-3992
Or write to the address shown above.

Notes: This is the claim detail for the bills received on 05/15/03.

Claim Activity for JOHN T DOE *(Self)*

Member: John T Doe
Group Name: ExxonMobil Medicare Supplement Plan

Member ID: Please refer to ID Card
Group Number: 0860816-00-000

			Patient Responsibility								
DATE AND TYPE OF SERVICE	SUBMITTED CHARGES	NEGOTIATED AMOUNT	NOT PAYABLE BY PLAN	SEE REMARKS	YOUR COPAY	YOUR DEDUCTIBLE	AMOUNT REMAINING	PAID AT	PLAN PAYS	YOUR SHARE OF AMOUNT REMAINING	Total Patient Responsibility
John T. Smith											
05/08/03 Office Visit	70.00		10.00	1			60.00	80%	48.00	12.00	12.00
05/08/03 Diag. X-Ray	20.00						20.00	80%	16.00	4.00	4.00
	A	B	C		D	E	F		G	H	
Column Totals	90.00		10.00				80.00		64.00	16.00	16.00

Less Amount Paid by Other Health Plan $64.00

John T. Smith May Bill You: **$16.00**
C + D + E + H = *I*

Remarks:
1 - THE PROVIDER HAS AGREED TO ACCEPT THE AMOUNT MEDICARE APPROVED AS THE CHARGE FOR THIS SERVICE. YOU ARE NOT LEGALLY RESPONSIBLE TO PAY MORE THAN MEDICARE'S APPROVED AMOUNT.

***Plan Summary for** 01/01/03 - 12/31/03*

Description Individual Limits	Annual Limit	Year To Date	Remainder
Medical Medicare Deductible	$250.00	$250.00	$00.00
Medical Medicare Share of Amount Remaining (Coinsurance)	$2,500.00	$266.00	$2,234.00
Individual Lifetime Maximums	**Limit**	**Used**	
Medical Medicare	$700,000.00	$00.00	

999999999 EK55T25L00

If You Have Questions or Need More Claim Forms

For Medical claims, call Aetna Member Services at 800-222-3992.
For Prescription Drug claims, call Medco Health at 800-695-4116.
Or visit Medco Health's website at **www.medcohealth.com**