aetna® Other Health Insurance Verification Form

The information below is correct to the best of my knowledge. I hereby authorize any other carrier to give to Aetna information about any coverage they provide in relation to myself and/or other family members.

Aetna subscriber signature (or parent/guardian signature) _____ Date _____

Section A. Subscriber Information — *To be completed by subscriber.*

Name (First, Middle Initial, Last)	ID number
Street Address, City, State, Zip Code	
Employer's group name ☐ **State of Alaska (AlaskaCare)**	Employer's telephone number
Type of plan ☐ HMO ☐ Open Choice ☐ Managed Choice ☐ Other _____	Policy/group number **866219**
Aetna subscriber ID number ***(as shown on your ID card)***	Are you employed by another employer/company? ☐ No ☐ Yes If **Yes** and you have coverage under another health plan, please, complete **Section D, or E for Medicare**.
Employment Status ☐ Active ☐ Retire - **date retired** _____ ☐ Receiving COBRA benefits ☐ Long-Term Disability ☐ Other _____	

Section B. Spouse/Qualified Same Sex Partner Information — *To be completed by subscriber.*

Name (First, Middle Initial, Last)	ID number
Employer's Name	Employer's telephone number
Employer's Street Address, City, State, Zip Code	
Employment Status ☐ Active ☐ Retire - **date retired** _____ ☐ Receiving COBRA benefits ☐ Long-Term Disability ☐ Other _____	
Does your spouse/qualified same sex partner have other coverage? ☐ No ☐ Yes If **Yes**, complete **Section D, or E for Medicare**.	

Section C. Dependent Information — *Complete each box for each dependent covered under your Aetna plan.*

Name (First, Middle Initial, Last)	Date of Birth **(MM/DD/YYYY)**	Relationship to the subscriber Above **C=Child; S=Stepchild; O=Other (specify)**	Address/telephone (if different from the subscriber above)	Covered under another group coverage **Y=yes; N=no**
1.				
2.				
3.				
4.				
5.				
6.				

If **Yes** is noted for **Covered Under Another Group Coverage** column on any of the dependent child(ren)/stepchild(ren) listed above, complete **Section D** and the following:

- Who are the legal parents of the child(ren)? _____
- Date of birth For each parent (MM/DD/YYYY) **father:** _____ **mother:** _____

If parents are separated or divorced, complete the following:

- Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical, dental, or other health care expenses? ☐ Yes ☐ No If **Yes**, specify who _____
- Who has custody of the dependent child(ren)? _____
- Who do the child(ren) reside with? _____
- How many months of the year? _____

Member number (required)

Section D. Other Insurance Carrier Name and Telephone Number — *Complete this section if you or your dependents are covered under another insurance plan.*

Name of other insurance carrier (1)		Other insurance carrier telephone number	
Name of subscriber of this policy	ID number *(as shown on your ID card)*	Effective date (MM/DD/YYYY)	
Employer's name		Employer's telephone number	Length of employment **year(s)** _____ **month(s)** _____
Type of coverage ☐ Family ☐ Individual	Type of benefit provided (check all that applies) ☐ Medical ☐ Dental ☐ Vision ☐ Student ☐ Pharmacy		
Who is covered under this group coverage *(enter individual's name)*: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Name of other insurance carrier (2)		Other insurance carrier telephone number	
Name of subscriber of this policy	ID number *(as shown on your ID card)*	Effective date (MM/DD/YYYY)	
Employer's name		Employer's telephone number	Length of employment **year(s)** _____ **month(s)** _____
Type of coverage ☐ Family ☐ Individual	Type of benefit provided (check all that applies) ☐ Medical ☐ Dental ☐ Vision ☐ Student ☐ Pharmacy		
Who is covered under this group coverage *(enter individual's name)*: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			

Section E. Medicare Coverage — *Complete this section if you, your dependent or your spouse is covered under Medicare.*

HEALTH INSURANCE SOCIAL SECURITY ACT	**HEALTH INSURANCE SOCIAL SECURITY ACT**
Name of beneficiary _____	Name of beneficiary _____
Claim number _____	Claim number _____
Sex _____	Sex _____
Is entitled to / **Effective date**	**Is entitled to** / **Effective date**
Hospital (Part A) _____	Hospital (Part A) _____
Medical (Part B) _____	Medical (Part B) _____
Medicare Advantage (HMO) _____	Medicare Advantage (HMO) _____
This is the information as it exists currently on your Medicare ID card.	*This is the information as it exists currently on your Medicare ID card.*
Entitled to Medicare due to (check all that applies): ☐ Age 65 ☐ Disability ☐ ESRD – Provide 1st dialysis date _____ – Provide kidney transplant date _____	**Entitled to Medicare due to** (check all that applies): ☐ Age 65 ☐ Disability ☐ ESRD – Provide 1st dialysis date _____ – Provide kidney transplant date _____

You can return this form to us by fax or mail:

Aetna
PO Box 14079
Lexington, KY 40512-4079
Fax: 1-859-455-8650

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 claim was provided by the applicant. "**Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).**