PSEG
We make things work for you.

CLAIM FORM FOR:
- SELECTLINE
- CHOICES
- BENEFITS 2000 NON-REPRESENTED
- BENEFITS 2000 REPRESENTED

LASIK EYE SURGERY BENEFITS CLAIM FORM
(or equivalent procedures for improved vision)

PLEASE PRINT ALL INFORMATION CLEARLY

EMPLOYEE'S FIRST NAME M.I. LAST	EMPLOYEE'S SOCIAL SECURITY NUMBER	EMPLOYEE'S BIRTH DATE MO. DAY YEAR
ADDRESS	MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ SEPARATED	STATUS ☐ ACTIVE ☐ COBRA
CITY STATE ZIP	WORK LOCATION	

USE A SEPARATE CLAIM FORM FOR EACH PATIENT (DO NOT USE "NICKNAMES.") ALL ITEMS MUST BE COMPLETED IN ORDER FOR YOUR CLAIM TO BE PROCESSED.

PATIENT'S FIRST NAME M.I. LAST	RELATIONSHIP TO EMPLOYEE	PATIENT'S DATE OF BIRTH

MAKE SURE ALL CHARGES ON EACH BILL ARE FOR ONE PATIENT ONLY. EACH BILL MUST INCLUDE THE PATIENT'S NAME, DATE(S) OF SERVICE, TYPE(S) OF SERVICE(S) PERFORMED, AND THE COST FOR EACH SERVICE.

IS TREATMENT THE RESULT OF AN OCCUPATIONAL ILLNESS OR INJURY? YES ☐ NO ☐	IS TREATMENT THE RESULT OF AN AUTOMOBILE ACCIDENT? YES ☐ NO ☐	IS TREATMENT THE RESULT OF ANOTHER ACCIDENT? YES ☐ NO ☐
NAME AND ADDRESS OF SPOUSE'S EMPLOYER, IF ANY	NONE ☐	SPOUSE'S DATE OF BIRTH
		SPOUSE'S SOCIAL SECURITY NUMBER

COORDINATION OF BENEFITS (COB)

IN THE CASE OF A CHILD BEING COVERED UNDER HEALTH PLANS OF BOTH PARENTS, PRIMARY COVERAGE (WHERE CLAIMS MUST FIRST BE FILED) FOR A DEPENDENT CHILD IS DETERMINED BY WHICH PARENT HAS THE EARLIEST BIRTHDAY IN THE CALENDAR YEAR.

IF THERE IS A CONFLICT BETWEEN DIFFERENT EMPLOYER PLANS WHERE ONE USES THE BIRTHDAY RULE AND THE OTHER USES THE GENDER RULE, THE GENDER RULE (FATHER'S COVERAGE PAYS FIRST) WILL BE FOLLOWED.

I HEREBY CERTIFY THAT THE SERVICE(S) LISTED ON THE ATTACHED ITEMIZED BILL(S) HAS BEEN PERFORMED. THE FEE(S) SHOWN IS THE ACTUAL FEE(S) CHARGED, AND ALL CHARGES HAVE BEEN PAID. I AUTHORIZE AETNA OR IT'S REPRESENTATIVE TO VERIFY CHARGES AND SERVICES WITH MY PHYSICIAN. I CERTIFY THAT I HAVE FULLY DISCLOSED ANY OTHER GROUP HEARING CARE BENEFITS TO WHICH THE PATIENT MAY BE ENTITLED.

EMPLOYEE SIGNATURE: DATE:

ATTACH ORIGINAL, ITEMIZED BILLS AND MAIL TO:

MAIL TO: →

AETNA INC.
ATTN: MARIANNE PIZZEMENTO
15 COLUMBIA CIRCLE
ALBANY, NY 12203

REV 10/01/2005

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