CLAIM INFORMATION FORM

Only one form is to be completed for each participant, to include all covered dependents per policy year (September 1 to August 31). Complete this form as soon as it is received and return it immediately to: TRS-Care/Aetna Service Center, P. O. Box 981106, El Paso, TX 79998-1106. If you have questions, call the TRS-Care/Aetna Service Center (800) 367-3636.

A. Covered Participant *(as shown on TRS-Care ID card)*

Name: (as listed on ID card) _____
First Middle Initial Last

Social Security/Identification No.: _____ Date of Birth: _____
(as listed on *TRS-Care* card) Month Day Year

Home Address: _____
Street City State Zip

Home Telephone: ( ) _____ Sex: ☐ Male ☐ Female

Do you have Medicare Part A (hospital insurance)? ☐ Yes ☐ No

Do you have Medicare Part B (medical insurance)? ☐ Yes ☐ No

Are you covered under any Group Health Insurance Plan other than TRS-*Care* or Medicare? ☐ Yes ☐ No

If yes, give the following:

Other Group Insurance Company Effective Date: _____

Name of other insurance: _____ Termination Date: _____

Phone #: _____ Currently Employed: ☐ Yes ☐ No

Policy Number: _____ Name of person insured: _____

Social Security No. of insured: _____

B. Covered Spouse Information *(Complete only if your spouse is covered by your TRS-Care coverage)*

Covered Spouse Name: _____
First Middle Initial Last

Spouse's Social Security No.: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female
Month Day Year

Does your spouse have Medicare Part A (hospital insurance)? ☐ Yes ☐ No

Does your spouse have Medicare Part B (medical insurance)? ☐ Yes ☐ No

Is your spouse covered under any Group Health Insurance Plan other than TRS-*Care* or Medicare? ☐ Yes ☐ No

If yes, give the following:

Other Group Insurance Company Effective Date: _____

Name of other insurance: _____ Termination Date: _____

Phone #: _____ Currently Employed: ☐ Yes ☐ No

Policy Number: _____ Name of person insured: _____

Social Security No. of insured: _____

C. Authorization

To all physicians and other health professionals, and all hospitals and other health care institutions including CMS: The undersigned person authorizes you to provide to Aetna and any independent consulting health professionals and utilization review organizations with whom Aetna has contracted information concerning health care, advice, treatment or supplies (including that relating to mental illness) provided to the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.

To Aetna and TRS-Care: The undersigned person authorizes Aetna to provide TRS-Care with, and TRS-Care is authorized to receive and use, information used in payment of claims for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of the coverage 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:** _____
(If acting for a member, a description of the signer's authority and supporting documentation is needed.)

Any person, who knowingly and with intent to defraud or deceive any insurance program, provides information or files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.
Complete the reverse side of this form if you cover a dependent child(ren).

B. Covered Dependent Child Information ***(Complete only if dependent child is covered by TRS-Care)***

Child's Name: _____
First Middle Initial Last

Child's Social Security No.: _____
Relationship to Participant: ☐ Natural ☐ Other relationship (explain) _____
Date of Birth: _____ Sex: ☐ Male ☐ Female
Month Day Year

Does your child have Medicare Part A (hospital insurance)? ☐ Yes ☐ No
Does your child have Medicare Part B (medical insurance)? ☐ Yes ☐ No
Is your child covered under any Group Health Insurance Plan other than TRS-*Care* or Medicare? ☐ Yes ☐ No
If yes, give the following:
Other Group Insurance Company _____ Effective Date: _____
Name of other insurance: _____ Termination Date: _____
Phone #: _____ Currently Employed: ☐ Yes ☐ No
Policy Number: _____ Name of person insured: _____
Social Security No. of insured: _____

B. Covered Dependent Child Information ***(Complete only if dependent child is covered by TRS-Care)***

Child's Name: _____
First Middle Initial Last

Child's Social Security No.: _____
Relationship to Participant: ☐ Natural ☐ Other relationship (explain)
Date of Birth: _____ Sex: ☐ Male ☐ Female
Month Day Year

Does your child have Medicare Part A (hospital insurance)? ☐ Yes ☐ No
Does your child have Medicare Part B (medical insurance)? ☐ Yes ☐ No
Is your child covered under any Group Health Insurance Plan other than TRS-*Care* or Medicare? ☐ Yes ☐ No
If yes, give the following:
Other Group Insurance Company Effective Date : _____
Name of other insurance: _____ Termination Date: _____
Phone #: _____ Currently Employed: ☐ Yes ☐ No
Policy Number: _____ Name of person insured: _____
Social Security No. of insured: _____

B. Covered Dependent Child Information ***(Complete only if dependent child is covered by TRS-Care Plan)***

Child's Name: _____
First Middle Initial Last

Child's Social Security No.: _____
Relationship to Participant: ☐ Natural ☐ Other relationship (explain) _____
Date of Birth: _____ Sex: ☐ Male ☐ Female
Month Day Year

Does your child have Medicare Part A (hospital insurance)? ☐ Yes ☐ No
Does your child have Medicare Part B (medical insurance)? ☐ Yes ☐ No
Is your child covered under any Group Health Insurance Plan other than TRS-*Care* or Medicare? ☐ Yes ☐ No
If yes, give the following:
Other Group Insurance Company Effective Date: _____
Name of other insurance: _____ Termination Date: _____
Phone #: _____ Currently Employed: ☐ Yes ☐ No
Policy Number: _____ Name of person insured: _____
Social Security No. of insured: _____