

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in-network. To use this form, you must: (1) Fill it out and sign it; (2) send it to your health care provider (include a copy of the bill or bills); and (3) send it to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:

1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician; OR
2. You were referred by a participating physician to a non-participating provider who provided services, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from our health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Your Name: _____

Your Address: _____

Insurer Name: _____

Your Insurance ID No.: _____

Provider Name: _____ Provider Telephone Number: _____

Provider Address: _____

Date of Service: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(Signature of patient)

(Date of signature)

Non-Discrimination Notice

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-866-337-8417.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14079, Lexington, KY 40512-4079 (CA HMO customers: PO Box 24030 Fresno, CA 93779), 1-866-337-8417, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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Availability of Language Assistance Services

TTY: 711

For language assistance in your language call 1-866-337-8417 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-866-337-8417. (Spanish)

欲取得繁體中文語言協助，請撥打1-866-337-8417，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-866-337-8417 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-337-8417 nang walang bayad.
(Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-337-8417 an. (German)

للمساعدة في اللغة العربية، الرجاء الاتصال على الرقم المجاني 1-866-337-8417. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-337-8417 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-337-8417.
(Italian)

日本語で援助をご希望の方は、1-866-337-8417 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-337-8417 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی با شماره 1-866-337-8417 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-337-8417. (Polish)

Para obter assistência linguística em português ligue para o 1-866-337-8417 gratuitamente.
(Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-337-8417. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-337-8417.
(Vietnamese)

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