Aetna HealthFund® Prescription Reimbursement

Katy Independent School District

PREPARING YOUR CLAIM FORM

- Complete section 1.
- Complete section 3 as applicable (list and separate expenses by individual family members).
- Complete section 4.
- Attach the appropriate documentation indicated below:
  - Pharmacy or Mail Order payment receipt
  - Statement from the pharmacy/Mail Order with the following:
    - provider name
    - patient name
    - date of service
    - drug name
    - drug quantity
    - RX or NDC#

A canceled check is not adequate documentation.

A pharmacy purchase printout is acceptable.

SUBMITTING YOUR CLAIM

- Retain copies for your files. Claim information cannot be returned.
- Send the completed claim form and documentation to:

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

Aetna Life Insurance Company's Member Service Professionals are available to provide you information on your plan. Please refer to the number on your ID card, or access your plan information through Aetna Navigator at www.aetnanavigator.com.

[Important Note] If you are submitting a claim with a change in your mailing address, you must notify your employer to make the change on your Aetna HealthFund® enrollment file to avoid misdirected claim payments.

1. Employee Information

Social Security Number	Name	Daytime Telephone Number
_ _		( )
Address (include zip code) ☐ Check if address is new		Home Telephone Number ( )

2. Employer Information

Employer Name	Control Number (as it appears on your ID card)
Katy ISD	**724976**

3. Expense Information

Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
	☐ Self ☐ Spouse ☐ Child ☐ Other		

Date(s) of Service (MM/DD/YYYY) From _____ Thru _____ **Total Amount Submitted $** _____

Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
	☐ Self ☐ Spouse ☐ Child ☐ Other		

Date(s) of Service (MM/DD/YYYY) From _____ Thru _____ **Total Amount Submitted** $ _____

Name	Relationship to Employee	Date of Birth (MM/DD/YYYY)	Age
	☐ Self ☐ Spouse ☐ Child ☐ Other		

Date(s) of Service (MM/DD/YYYY) From _____ Thru _____ **Total Amount Submitted $** _____

4. Employee Certification

I certify that all expenses for which reimbursement is claimed from the Aetna HealthFund® have been incurred and have not been reimbursed and are not reimbursable under any other health plan coverage. I understand that I am required to submit, in addition to this claim form, an invoice or other statement from a health care provider or other independent third party stating that the expenses have been incurred and the amount of such expense. I represent that any individual (other than the employee or the employee's spouse) for whom a claim is filed hereunder qualifies as a dependent of the employee for federal income tax purposes. I further declare that I have not and will not deduct these expenses on my federal, state or local income tax returns.

Employee Signature _____ Date _____

Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.