aetna®

Aetna
PO Box 14079
Lexington, KY 40512-4079

ant.
EXAMPLE

7-21-2016

DCN# [redacted]

[redacted]

Plan Sponsor Name: [redacted]
Subscriber Name: [redacted]
Patient Name: [redacted]
ID Number: [redacted]

Subject: Verification of Eligibility

Dear Ms. [redacted]

This letter is in response to your request for written confirmation that the above named patient is eligible for medical insurance coverage. The above named patient became effective with us on 01-01-2016 and is enrolled in an Aetna Choice POS II Plan.

With this type of plan, the patient is not required to select a Primary Care Physician and referrals are not required to see another participating specialist.

This is not a guarantee of payment, only verification of eligibility. The patient must be eligible for coverage on the date services are received. If the subscriber's and/or the dependent's status has changed with the plan sponsor (usually the employer), please contact the plan sponsor because terminations based on eligibility can be retroactive.

Benefit coverage is determined based on the patient's actual eligibility on the date services are rendered and is subject to all plan provisions and exclusions actually in effect on that date. Please refer to your plan documents for further information regarding benefits and exclusions.

Please send all claims to:

Aetna
P.O. BOX 14079
LEXINGTON, KY 40512-4079

If you have any questions, please contact Aetna Member Services at [redacted] or log on to **www.aetna.com** and select "Contact Us".

Sincerely,

Janel Vazquez

Janel Vazquez
Customer Service Representitive
Local & Regional Businesses Operations

CC: REESE J SIM