Wig Member Reimbursement Form

Section 1: Member information *(print clearly)*

Aetna® member ID:

Date of birth *(MM/DD/YYYY):*

Phone number *(with area code):*

Last name:

First name:

Middle initial:

Email:

Street address:

City:

State:

ZIP code:

Section 2: Claim request *(information must match your itemized bill)*

Date of service or purchase *(MM/DD/YYYY):*

Reimbursement type: ❑ Wigs

Amount paid:

$, .

Wig(s) purchase requirements:

- Purchase of wig due to hair loss from chemotherapy treatment
- CPT code: A9282
- Diagnosis codes: Z51.11, Z92.21

Member comments (optional):

Section 3: Point of sale transaction for retail store or website

Name of retail store, website, etc.:

Street or website address:

City:

State:

ZIP code:

Section 4: Signature

By signing and submitting this form, you certify that the information is true and correct.

_____ _____

Member or authorized representative signature **Date**

Section 5: Acknowledgment

Questions?

We're here to help. **If you have questions, please call Member Services at 1-855-463-0933, (TTY: 711)**, 8 AM to 8 PM, 7 days a week.

Important disclaimers

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. Plan features and availability may vary by service area.

Reimbursement instructions

How to complete this reimbursement form

When to use this form

1. Fill out this form if you're asking for reimbursement of a wig that you or your authorized representative purchased directly.
2. Please fill out a separate form for each wig you purchased. You can only be reimbursed up to your annual benefit amount. If you purchase more than one wig, remember to submit this form and receipts for each wig.

How to fill out this form

1. Complete each section. Print clearly. If you need assistance with the form, please call Member Services at **1-855-463-0933, (TTY: 711)**, 8 AM to 8 PM, 7 days a week.

2. Sign and date the bottom of the completed form. If you are filling this in on someone else's behalf, there must be an appointed representatives form on file. This form can be found at: **AetnaBetterHealth.com/virginia-hmosnp/members/hmo-snp/forms**
   Make sure to send the completed AOR form with the request for reimbursement.

Where to send the completed form

1. Make copies or take a picture of all of your receipts. Be sure to include your Aetna® member ID number on each receipt or copy of the receipt. Any receipts or copies that are submitted will not be returned to you.

2. The receipt must clearly state what was purchased, when it was purchased, how much it cost and how it was paid for.

3. Mail this completed form and your receipts to: **Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998-2980**

4. You can also submit your request through email. Email the form and your receipts to: **oh_memberservices@aetna.com** (Helpful hint — If you can use your phone to take a clear picture of the receipt, you can send the picture of the receipt along with the reimbursement form.)

Things to remember

1. Please submit this form within 365 days from the date of service or transaction.
2. Please complete all required information. If your request is incomplete, it will delay processing time. We will reach out to you for any missing information. If we cannot obtain the missing information, your claim will be denied.
3. If we approve your request, it can take up to 45 days to send payment once we have all the required information.