HEALTHCARE WORKSHEET

Description of Issue *(including date of service, claim number, dollar amounts, other dates, etc.)*:

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_____

Contact with Aetna

Time/Date: _____ Call Reference Number: _____
Representative's Name/ID: _____
Description: _____
_____
_____

Time/Date: _____ Call Reference Number: _____
Representative's Name/ID: _____
Description: _____
_____
_____

Contact with Provider *(provider's name)*: _____

Time/Date: _____
Representative's Name/ID: _____
Description: _____
_____
_____

Time/Date: _____ Call Reference Number: _____
Representative's Name/ID: _____
Description: _____
_____
_____

Medical Bill Tracking*

Date of Service	Provider	CPT Code	Claim Amount	Negotiated Rate	Amount Paid by Plan	Amount Toward Ded/OOP*	Amount I Owe/Paid

*If you need more space for Medical Bill Tracking, please contact the HCA to receive an excel spreadsheet.
**This is the amount that counts toward your annual deductible and out-of-pocket (OOP) maximum for the year.

If you have any questions or require assistance, please email the Healthcare Advocates at healthcareadvocates@akcourts.us. Please feel free to attach this worksheet along with any pertinent Explanation of Benefits (EOBs).