

## Field Descriptions for the Consolidated Family Statement - Medical

**1 – [Mailing address].** Name and mailing address for the member.

**2 – Questions?** Customer specific contact information (website and/or telephone number) to use for any questions.

**3 – Notes.** Displays optional messages.

**4 – Member.** First and last name of member.

**5 – Group Name.** The name of the plan sponsor.

**6 – Member ID.** The customer member ID used on the member's ID card. **Group Number.** The control, suffix, account, plan summary and PI record.

**7 – Claim Activity for [Name].** First and last name of patient with middle initial.

**8 – [Relationship].** Relationship of patient to the member.

**9 – Patient Responsibility.** The shaded columns (C, D, E, H) are amounts for which patient is responsible. See fields #21, 26, 27.

**10 – Date and Type of Service.** The provider name, month, day and year the service was provided, and brief description of the service.

**11 – Submitted Charges.** The amount billed for this service.

**12 – “Negotiated” or “Allowed”.** Negotiated = the special fee for this service negotiated with a provider who participates in the network. Allowed = the amount allowed for a provider not participating in the network.

**13 – Pending or Not Payable.** The amount being pended or denied. The next field (#14) points to the reason. *Note: this amount is excluded from the total in field #21 if no patient responsibility applies.*

**14 – See Remarks.** Corresponds to the remark with this number in field #28.

**15 – Your Copay.** Patient copayment for the services rendered.

**16 – Your Deductible.** Patient deductible applied to the difference between fields #12 and 13 (or #11 and 13 if out of network).

**17 – Amount Remaining.** The amount on which the benefit is calculated.

**18 – Paid At.** The percentage used to calculate benefits.

**19 – Plan Pays.** The amount your plan will pay for this service in absence of any adjustments in field #22.

**20 – Your Share of Amount Remaining.** Also known as “coinsurance”. The portion of the allowable charges for which the member is responsible.

**21 – Total Patient Responsibility.** Indicates the total amount for which the patient is responsible. This includes not covered, copay, deductible and coinsurance amounts.

**22 – [Claim Adjustments].** An amount that may impact the benefit Aetna will pay, such as the amount paid by another health plan, or a late claim interest amount (shown here on one claim only). *Note: when field #22 exists, then field #27 is suppressed.*

**23 – [Received Date].** Date this specific claim was received by the claim office, with a unique date displayed for each claim.

**24 – Claim ID.** For internal Aetna use: Claim ID number, with a unique number displayed for each claim.

**25 – Form ID.** For state regulatory filing. Currently for Virginia residents only; otherwise left blank.

**26 – [Provider Name] May Bill You.** Totals for which the member is responsible. See field #27.

**27 – C+D+E+H=I.** These “shadow” letters identify columns and demonstrate how patient responsibility (amount provider may bill you) was calculated in field #26. *Note: this is suppressed if field #22 (claim adjustment) displays, since the formula is then invalid.*

**28 – Remarks.** Explain denied or pended charges, or provide additional information. Correspond to expense lines above with the same number in field #14.

**29 – Plan Summary for [benefit year].** Summary of plan financial limits for the benefit year listed.

**30 – Payment Summary.** Payee, date sent and payment amount.