ECHS Category - HNST

New Jersey State Health Benefits Program
Emergency Room Referral Form

This form is for New Jersey State Health Benefits Program members participating in the Aetna HMO, Aetna Freedom 10, Aetna Freedom 15 and Aetna Freedom 1525 plans. If you were referred by your physician to the emergency room, to receive a lower emergency room copayment for your visit this form must be completed in its entirety by your referring provider and faxed to the number below. This form must be completed and faxed within 12 months of your emergency room visit to request the lower copayment for your Emergency Room Visit. This form does not apply to SEHBP members.
Please fax completed form to **1-859-455-8650.**

If you have questions about this form please contact our Member Services at **1-877-STATENJ**.

Part A. REFERRING PROVIDER INFORMATION

Provider Name *(First, MI, Last):* ______________________________

Provider ID Number: ______________________________

Emergency Room Service Date: ______________________________

Place of Service: EMERGENCY ROOM ______________________________

Part B. PATIENT INFORMATION

Patient's Name *(First, MI, Last):* ______________________________

Patient's ID Number: ______________________________

Patient's Date of Birth: ______________________________

Part C. REFERRED TO SECTION

Referred to Facility: ______________________________

Referred to Facility ID: ______________________________

Diagnosis Code: ______________________________

Comments: ______________________________

Referring Physician Signature:____ ***Date:*** ________

For more information specific to your benefits please contact member services at www.aetnastatenj.com or contact member services at 1-877-STATENJ.