



**HEALTHCARE AUDIT REWARD PROGRAM (HARP)**

Employee Name: \_\_\_\_\_

Employee ID Number: \_\_\_\_\_

Department: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Name of the Provider/Physician: \_\_\_\_\_

Please identify the type of service provided:

Physician Office Visit

Vision

Inpatient Hospital Stay

Dental

Outpatient Services including Lab & X-ray

Other \_\_\_\_\_

In the space below, please describe the error you identified on the EOB:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You are required to contact the service provider **AND** Aetna to discuss the error. Please provide the date of the call, name of the person contacted, and the resulting discussion.

Service Provider contacted: \_\_\_\_\_ Person Contacted: \_\_\_\_\_  
(Date)

Resulting discussion: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Aetna contacted \_\_\_\_\_ Person Contacted: \_\_\_\_\_  
(Date)

Resulting discussion: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*Please attach a copy of the Explanation of Benefits (EOB) to this form and return to the Benefits office. This form will be returned to you if any part is incomplete or if the EOB is not attached.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date