aetna[SM]

Claim Form

☐ **Medical*** ☐ **Pharmacy*** ☐ **Dental***

**** Refer to your plan documents to verify the coverage available through your plan.***

Aetna International

Please also complete page 2 of this form.

Please mail or fax the completed Claim Form with itemized bills and receipts. A separate Claim Form is needed for each family member. Please tape small receipts on a full size sheet of paper.

Aetna International
PO Box 30545
Tampa, FL 33630-3548

Telephone: + 1-866-949-6027 (toll-free)
+ 1-813-775-0034 (collect)
Facsimile: +1-860-262-9111 (direct dial)
E-mail: AmericasServices@aetna.com

1. Subscriber Information

Policy Number _____

Subscriber's Name _____

(First Name, Middle Initial, Last Name/Surname as displayed on Aetna ID Card)

Identification Number *(Use the number specified on your Aetna card)* | | | | | | | | |

Subscriber's Birthdate *(mm/dd/yyyy)* | | / | | / | | | | | Gender ☐ Male ☐ Female

Street _____

City _____ State/Province _____

Country _____ Postal Code _____

Subscriber's Telephone Number *(Include Country Code)* _____

Subscriber's Primary E-Mail Address _____

(E-mail addresses are strongly encouraged if we need additional information to process your claim.)

2. Patient Information

Patient's Name *(First Name, Middle Initial, Last Name/Surname)* _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient's Birthdate *(mm/dd/yyyy)* | | / | | / | | | | | Gender ☐ Male ☐ Female

Report cards, tuition statements and other forms of school attendance verification may be required once per school year, if your plan includes eligibility guidelines that require school attendance as a condition of coverage for dependents in excess of a specific age. See your plan documents for additional details.

3. Summary of Medical, Pharmacy and Dental Services (Please include diagnosis or reason for treatment for each service received.)

- **For prosthetic services** (crowns, bridges or dentures), the following information must be supplied:
- The x-rays. (If x-rays are not available, provide the dentist's narrative report.)
- For dentures and bridges: the date or dates of extraction of teeth involved. If it is a denture or bridge replacement, include the date of prior placement and reason for replacement.
- If the claim is for a bridge or denture, we will need a chart of all other missing teeth in the mouth, and their dates of extraction.
- For periodontal services (gum disease), you must submit x-rays and periodontal charting.
- For orthodontic services, the following information must be provided: date appliance placed, number of months of treatment, months of treatment remaining.
- For services related to an accidental injury, you must always include pre-treatment x-rays and details of the accident.

Dates of Service (mm/dd/yyyy)	Provider's (physician, clinic, hospital, pharmacy) Name and Address (If the provider's name and address is on receipts, write "see receipts")	Description of Service/ Name of Medication/ Drug/Device (If hospital, indicate inpatient or outpatient)	Diagnosis (Reason for visit)	City/State/ Province/Country of Claim	Currency of Claim	Total Charge

4. Claim Information

If Yes is answered to either question below, **c** and **d** in this section must be completed.

a. Is the claim related to a work related accident or condition? ☐ Yes ☐ No

b. Is the claim related to an accidental injury? ☐ Yes ☐ No

c. Accident Date *(mm/dd/yyyy)* | | / | | / | | | | | Time _____ ☐ AM ☐ PM

d. Description of Accident *(How and Where)*

_____

_____

Subscriber's Name _____
(First Name, Middle Initial, Last Name/Surname)

5. Your Aetna plan of benefits includes the option of claim reimbursements in a variety of currencies and disbursement methods. Establish your selected option in the sections below. Aetna reserves the right to issue the benefit reimbursement in the mode of payment available for the currency type, as circumstances dictate.

If you elect reimbursement in a U.S. dollar check, skip to **Section 6.** Continue with **Sections 5, 6 and 7** for all other reimbursement methods**.**

Please check one of the following (as applicable):

- ☐ Use the Recurring Reimbursement Election (RRE) information currently on file.
- ☐ Use the information provided in section 6 and/or 7 to establish an RRE.
- ☐ Update the current RRE information on file with the information provided in Section 6 and/or Section 7.
- ☐ Use the information provided in section 6 and/or 7 only for expenses related to this claim form.

6. Summary of Reimbursement – Only one method of reimbursement and currency will be honored per claim form.

Send Payment To: ☐ Subscriber ☐ Provider

Requested Reimbursement Method	**Country/Currency Type for Reimbursement (i.e., Great Britain / Pounds) If the currency you have elected is not available for the method requested, we will default reimbursement to US ($).**
☐ Funds Transfer (Preferred) **The most efficient method of transferring funds. Please check with your bank for help with providing the appropriate instructions to us.**	
☐ Check (Go to section 8)	

7. Bank Information

Primary Bank – Required if funds transfer, as available, is your preferred reimbursement method as specified in Section 5. (We can transfer reimbursements to your bank at no cost. However, we encourage you to check with your bank to determine the fee your bank may charge you for these transaction(s).) The following information is required if you have elected funds transfer as your preferred method for reimbursements.

Bank Account Number _____

Name of Accountholder *(As it appears on the Bank Statement)* _____

Bank Identification Code/Routing Number _____

☐ S.W.I.F.T./BIC Code (wire only) ☐ CHIPS UID ☐ Federal ABA ☐ Bank Sort ID ☐ IBAN* ☐ Other _____

*The IBAN is mandatory for bank transfer claim payment transactions in certain countries, such as the United Arab Emirates (UAE). This must be supplied if you are using a bank account in one of these countries. Members should check with their bank to confirm any IBAN requirements.

Bank Name _____

Bank Address *(Include Country)* _____

Bank Telephone Number *(Include Country Code)* _____

8. Other Health Coverage/Scheme

Are any family members' expenses covered by another health plan/scheme, National, Social government, Medicare or any U.S. Federal or U.S. State plan? ☐ Yes ☐ No If "Yes," complete the information below.

Name and Relationship of the Family Member _____
(First Name, Middle Initial, Last Name/Surname)

Family Member's Birthdate *(mm/dd/yyyy)* | | | / | | | / | | | | | Gender ☐ Male ☐ Female

Name of other Insurance Company or Type of Insurance _____

9. Authorization (Required)

For All Electronic Deposits: I hereby authorize Aetna Life & Casualty (Bermuda) Ltd. and/or their dedicated agents to make payments of any benefits payable to me and/or my dependents, by crediting such payments to my account at the bank or financial institution named on this form. I agree to notify Aetna in writing of any changes relating to the information provided on this form or withdrawal of this authorization. I agree that if, for any reason, unearned benefit payments are deposited into my account, I will immediately repay the full amount of any such payments. I further agree that if I do not immediately repay such payments, I will personally be liable for all costs of collection (including reasonable attorney's fees and the maximum interest permitted by law).

Medical, Pharmacy, and Dental Authorization. Must be signed and Dated: I authorize all physicians, other health professionals, pharmacies/pharmacists, hospitals and health care institutions to provide Aetna and any independent parties acting on Aetna's behalf or with whom Aetna has contracted, information concerning health care, advice, treatment or supplies provided to the patient (including that related to mental illness and/or AIDS/ARC/HIV). This information will be used for the purposes of evaluating and administering claims. Aetna may provide the employer named on this form with any benefit calculation used in the payment of this claim for the purpose of reviewing the experience and operation of the policy/contract. This authorization is valid for the term of the policy or contract under which a claim is submitted. I know I have a right to receive a copy of this authorization upon request and agree that a copy of this authorization is as valid as the original.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

Patient's or Authorized Person's Signature _____ Date *(mm/dd/yyyy)* _____