**Aetna International** 



# **Claim Form for Medical Treatment Reimbursements**

## Please complete clearly in BLOCK CAPITALS.

One form must be completed for each patient, for each medical condition treated.

The sections marked by an asterisk (\*) must be completed in full by the patient, or the main member on behalf of the patient if the patient is a dependant under the age of 18. Assessment of the claim may be delayed if all the necessary sections of this form are not completed.

* Section 1 Main memb	er/claim	ant d	letails	i																			
Title Mr Mrs Miss Ms							F	Family name (surname):															
First name:								Middle name:															
Date of birth (mm/dd/yyyy) Sex																							
ID number (as shown on your A																							
Policy number (as shown on yo																				—			
Group name:																							
Correspondence address: Country:																							
Postcode:								ounti	у.														
E-mail:																				T			$\Box$
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Daytime phone								venir	ıg	phone								_		=	_		
* Section 2 Patient deta	ilo /if di	Horo.	at fran	~ ~ ~	otio	n 1\														—			
	•			n se	Ctio	n 1)																	
Title Mr Mstr Mrs										ame (										—			
										ame: Male													
Date of birth (dd/mm/yyyy): ID number (as shown on your A								ex	Ш	IVIAIE	Ш	rei	IIak	<del>-</del>									
TE Hamber (as shown on your /	Tetria care	1, 11 00	raid be	0 01	O GIĘ	jito)														_			
* Section 3 Claim detai	ls																			_			
Detail the symptoms/medical co		at the	patier	nt red	ceive	d trea	tmen	t for:															
Is this claim for a wellness che	ckup?	Y	es [	□N	0	If 'Ye	s', Se	ection	6	does	not n	eed	d to	be o	con	nple	ete	d					
Is this claim for optical care?	<u> </u>		es	N	0					loes n													
If this claim is not for a wellness	s chackun	or o	otical c	ara	ie it:	on th	e iast	two p	ag	es of t	nis ic	orrri	IOI	ine c	100	ume	eni	s yo	u ne	eu	เอรเ	ווומג	IL.
a new claim?	3 CHCCKup		_	,aic, □ N		If 'No	'. pro	vide 1	he	previ	ous (	clair	n n	umb	er								
a claim for a repeat prescription	n?			<u></u> N						does													
Is this a claim for hospital cash	benefit?	□ Y	es [	□N	o																		
If 'Yes', Section 6 must be complischarge form from the hospital													se	senc	u b	s the	e 0	rigin	al ad	imt	ssio	n an	d
If 'No', provide the breakdown of	the invoice	es bei	ng subi	mitte	d with	n this	claim:																
Country of treatment	Date of	treat	ment		Invoi	ce da	ite	Inv	oic	e ref	eren	се	lnv	oic	e a	mo	un	t (in	clu	din	g cı	ırre	ncy)
Use a separate sheet if you need more space.  Total number of invoices:																							
Does the patient have another If 'Yes', provide the other insurenumber with that insurer:												_	] N		the	е ра	tie	nt's	plar	ı or	poli	су	
le the claim as a result of a very	oide = tO	71/-		NI-																_	_		_
Is the claim as a result of an ac If 'Yes', provide the circumstan	-	Ye	_	No Judir	a ha	w it h	anno	and t	·ho	locat	on t	ha t	time	200	4 tl	20 d	lat	O 116	sina	٠,	ona	rata	
sheet if you need more space:		acciu	ent inc	Juuii	ig no	VV IL II	арре	ieu, i		locat	OΠ, τ	116 1	LIITIE	an	u ii	ie u	ıaı	=, us	siriy		<del>.е</del> ра	Tale	
If the patient has suffered an in If 'Yes', provide the other insure							-		_			d p	arty	/?		Yes	3		No				

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* Se	ection 4	Declaration – the Declaration must be signed by the patient or the main me	mber if	the	patie	nt is	а
Aetr repr the i	na will rely o esentatives, member/cov	the best of my knowledge, all the information provided on this Claim form is truthful and con the information provided as such. I agree and accept that this declaration gives Aetna, and the right to request past, present, and future medical information in relation to this claim, or ered individual, from any third party, including providers and medical practitioners. I declare be collected, held, disclosed, or transferred (worldwide) to any organization within the Aetn any affiliates.	d its app any othe and agr	ointe er cla ee th	d im rel at per	ated sona	
Pati	ent's/main n	nember's signature:	Date (m	n/dd	yyyy)	:	
* Se	ection 5	Payment details					_
		to pay the provider directly?    Yes    No					
-		only make payment to the provider if their bank details are included on the invoice.					
Hav	e you perso	nally had to pay costs for the treatment that you are claiming for?   Yes   No					
lf 'Y	es', and you	are personally seeking reimbursement, you must tell us how you wish to be reimbursed by oreign draft' / 'Cheque', and completing the required information.	ticking e	ither	1, 'Ba	nk	
If ar	other perso	n or entity has paid on your behalf please give their name:					
Diag	aa tiak ana						
Piea		of the following as applicable ring Reimbursement Election (RRE) information currently on file					
		nk information provided in this section as your permanent RRE					
		nk information provided below only for expenses related to this claim					
Fail	ure to compl	ete all information for the chosen reimbursement method may result in you, the named pers	son or en	tity:			
•	experiencir	ng delays in receiving the claim settlement; and					
•	incurring a	dditional bank charges.					
	1. Bank tra	nsfer – this is the quickest and safest method of payment					
		count holder:					
	If the claim	nant's name (as given in Section 1) is different to the account holder name, please prov	ide the f	ollov	ving (	letail	s
	Address of	account holder:					_
	E-mail add	ress of account holder:					
	Telephone	number of account holder:					
	Relationshi	p to the claimant:					
		unt details					
		::					
	Bank addre	ess (including town/city and country):					-
	BIC/SWIFT	code:					_
		urrency:					
	Currency o	f bank account:					
	Account nu	mber:					
		direct your payments efficiently, supply the following as relevant					
	IBAN numb	per (mandatory for all payments to bank accounts in countries that have adopted IBAN):					
	Sort code (	mandatory for UK located banks):					
	Routing co	de/Branch code (as available):					
	ABA numb	er (mandatory for transfers to US located banks:					_
	2 Foreign	draft / chaqua					
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	· ·aiiio io ap	pear on and didner onlydder					

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Currency of the draft / cheque:

Section 6 Medical – must be completed by the medical practitioner/specialist/therapist
1. Contact and registration details
Name of medical practitioner/specialist/therapist:
Qualifications:
Tax Identification Number (required for providers practising in the US):
Phone: Fax:
Address: Town:
Country: Postcode:
E-mail:
Date the patient first registered with you/the clinic/the hospital (mm/dd/yyyy):
2. Symptoms
a) Provide full details of the symptoms presented:
b) Has the patient suffered from the same or similar symptoms before?
If 'Yes', specify the medical condition:
c) On what date did the patient first notice these symptoms (mm/dd/yyyy)?
d) On what date did the patient first present these symptoms to you (mm/dd/yyyy)?
e) Has the patient had any treatment for these symptoms or diagnosed medical condition before?   Yes  No
If 'Yes', specify the type of treatment:
and the date (mm/dd/yyyy):
3. Diagnosis
Diagnosis of medical condition, if known: ICD code:
Is there any underlying cause? ☐ Yes ☐ No
If 'Yes', provide details:
Is the medical condition as a result of an accident?
If 'Yes', was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident? $\square$ Yes $\square$ No
Treatment proposed:
Investigations requested, if any:
La companie de la la constitución de la constitució
In your opinion, is this condition: Acute Chronic Acute episode of a chronic condition
4. Type of alternative treatment recommended, if relevant  Physiotherapy Osteopathic Traditional Chinese medicine Podiatry Number of sessions needed?
5. Referrals
a) Was the patient referred to you?
If 'Yes', please complete the following
Name of referring practitioner: Date of referral (mm/dd/yyyy):
Qualifications: Phone:
If 'Yes', provide the following details:
Name of specialist you referred the patient to:
Date of referral (mm/dd/yyyy): Phone:
Please provide a copy of the referral letters.
6. Hospital admission
Has the patient been admitted to hospital for this condition?
If 'Yes', provide the following details:
Admission date (mm/dd/yyyy): Discharge date (mm/dd/yyyy):
7. Declaration
I declare that to the best of my knowledge and belief the information I have given in the Medical section of this Claim form is full, true and complete.
Medical practitioner's/specialist's/therapist's signature:  Date (mm/dd/yyyy):
Practice stamp
· -

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### How to complete this form

One form must be completed for each patient, for each medical condition treated.

Assessment of the claim may be delayed if the patient/main member and the patient's medical practitioner, specialist or therapist do not complete all the necessary sections of this form.

Sections 1 to 5 must be completed by the patient, or the main member on behalf of the patient if the patient is a dependant under the age of 18.

Section 6 must be completed by the patient's medical practitioner, specialist or therapist unless the claim is for:

- a repeat prescription for medication to treat a chronic medical condition and we have previously approved and paid claims for the same medication to treat the same chronic medical condition;
- optical care; in this instance you need to send us the optometric prescription and the itemised invoice for the prescription spectacle lenses, prescription spectacle frames and prescription contact lenses; or
- a wellness checkup.

For any other type of claim, we understand that it may not always be possible to have Section 6 completed by the medical practitioner, specialist or therapist. In such circumstances, we will process the claim if the invoices and receipts for the treatment costs incurred contain all of the following:

- diagnosis of the medical condition treated;
- treatment date:
- type of treatment; and
- the medical provider's official stamp.

We may need to contact the patient's medical practitioner, specialist or therapist for more medical information in order for us to process the claim under the terms and conditions of the policy. We will tell you if we need to do this.

A quick guide on how to submit your claim. For detailed information, please refer to the "Your guide to making a claim" section in your Member Handbook.

Send us the claim within 180 days of the first treatment date. You must send the following items to make sure that we can process your claim:

- the fully completed Claim form;
- the original itemised invoice;
- the original receipt. We do not accept credit card statements as proof of payment;
- a copy of the prescription if you are claiming for medication;
- a copy of the investigative tests results where relevant (e.g. blood tests, x-rays, ultrasound, MRI / CT scan/ PET scan, audiometry, etc.);
- a copy of the physiotherapy or alternative treatment (chiropractic, osteopathic, homeopathic, etc.) referral by the medical practitioner
  or specialist if you are claiming for physiotherapy or alternative treatment costs; and
- copy of the admission and discharge reports where relevant for inpatient or daycare admissions.

#### Important information

Please remember these important points when completing your Claim form.

## Section 3 - Claim details

If the patient has another insurance plan or policy that covers him/her for medical costs, we will need to know the details as it may affect the amount we pay in respect of their claim.

#### Section 4 - Declaration

If the declaration has not been read and signed, we will not be able to process the claim.

(continued)

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## How to complete this form (continued)

#### Section 5 - Payment details

- If you are not personally seeking reimbursement we will pay the treatment provider directly, as long as the payment instructions are shown clearly on the invoice.
- If you are personally seeking reimbursement, we will only issue payment to:
  - the patient if they are 18 or over;
  - the plan holder if the patient is under 18 and is a dependant under the plan; or
  - the parent or legal guardian named as the primary member, if the patient is under 18.
- Ensure that you are able to receive payment in the method and currency you have requested.
- We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or recipient bank service charges. Please
  contact your bank for further details.
- If you do not give us the sort code/routing code, BIC/ SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.
- Payment by foreign draft / cheque in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft / cheque. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the base currency of your plan. For the current list of applicable currencies and countries please refer to our website.
- We cannot issue non-QAR foreign drafts/cheques to members/providers with bank accounts based in Qatar as the banks will
  not allow those to be encashed.
- Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of
  the payment and is outside our control.
- Whenever coverage provided by any insurance policy is in violation of any US, UN or EU economic or trade sanctions, such
  coverage shall be null and void. For example, Aetna companies cannot pay for health care services provided in a country under
  sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more on the
  US Treasury's website at: <a href="https://www.treasury.gov/resource-center/sanctions">www.treasury.gov/resource-center/sanctions</a>

We know you may have questions and we're always here to help. You can call us any time on the phone number listed on the back of your Aetna ID Card.

You can also send us a secure e-mail by logging in to www.aetnainternational.com and clicking 'Contact us'

You can scan your claims to us, rather than post them. It is important that any claim you send to us is done either by scan or originals, but not both.

## Send your claim to

• By post:

Aetna Global Benefits (Europe) Limited 1st Floor 69 Park Lane Croydon, CR9 1BG United Kingdom

- For the quickest and most convenient way of submitting your claim, please register for the secure member website at <a href="https://www.aetnainternational.com">www.aetnainternational.com</a> and submit your claim online.
- Send your claim via fax attaching receipts and all required documents from your medical practitioner, as explained above, to: +44 870 442 4387
- Send your claim via email with copies of your reciepts and all required documents from your medical practitioner, as explained above, to: <u>EuropeServices@aetna.com</u>
- For claim related queries please contact our 24 hour Member Services helpline at: +44 870 442 4386

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Aetna companies cannot pay for health services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more at US Treasury's website at <a href="https://www.treasury.gov/resource-center/sanctions">www.treasury.gov/resource-center/sanctions</a>

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