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.

Further information about how to complete this form can be found on the last two pages.

* Section 1: Main member/claimant details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other: _____

Family name (surname): _____ First name(s): _____

Date of birth (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Member ID[1]: _____ Plan number: _____

Plan sponsor: _____

Correspondence address: _____

Town: _____ Postcode: _____ Country: _____

E-mail: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Daytime phone: _____ Evening phone: _____

[1] as shown on your Member ID Card - it could be 6 or 8 digits.

* Section 2: Patient details (if different from Section 1)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other: _____

Family name (surname): _____ First name(s): _____

Date of birth (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Member ID[1]: _____

Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.

* Section 3: Claim details

Is this claim for a general wellness checkup?	☐ Yes	☐ No	If 'Yes', Section 6 does not need to be completed.
Is this claim for optical care?	☐ Yes	☐ No	If 'Yes', Section 6 does not need to be completed. Refer to the instructions on the last two pages of this form for the documents you need to submit.
Is this claim for a repeat prescription for an existing medical condition we have reimbursed you before?	☐ Yes	☐ No	If 'Yes', Section 6 does not need to be completed and you must provide the relevant claim number: _____
Is this a new claim?	☐ Yes	☐ No	If 'Yes', complete the following and refer to 'How to: complete this form' for further advice.

What symptoms did the patient have which needed treatment? _____

_____

_____

Confirm the medical condition or diagnosis if known: _____

Is this a claim for hospital cash benefit? ☐ Yes ☐ No

If 'Yes', Section 6 must be completed by the medical practitioner or specialist. Once completed, please send us the original admission and discharge form from the hospital where the treatment was provided together with this Claim form.

If 'No', provide the breakdown of the invoices being submitted with this claim:

Country of treatment	**Date of treatment** (dd/mm/yyyy)	**Invoice date** (dd/mm/yyyy)	**Invoice reference**	**Invoice amount** (including currency)
Use a separate sheet if you need more space.				Total number of invoices:

Does the patient have another insurance plan or policy that covers medical costs? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name of the insurer, the insurer's address and the patient's plan or policy number with that insurer: _____

_____

Is the claim as a result of an accident? ☐ Yes ☐ No

If 'Yes', provide the circumstances of the accident including how it happened, the location, the time and the date, using a separate sheet if you need more space: _____

_____

If the patient has suffered an injury as the result of an accident, are they claiming from a third party? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name and the plan number below:

_____

*Section 4: Declaration – the Declaration must be signed by the patient or the main member if the patient is a dependant under the age of 18

I declare that, to the best of my knowledge, all the information provided on this Claim form is truthful and correct. I understand that Aetna will rely on the information provided as such. I agree and accept that this declaration gives Aetna, and its appointed representatives, the right to request past, present, and future medical information in relation to this claim, or any other claim related to the member/covered individual, from any third party, including providers and medical practitioners. I declare and agree that personal information may be collected, held, disclosed, or transferred (worldwide) to any organisation within the Aetna group, its suppliers, providers and any affiliates.

Patient's/main member's signature:	Date (dd/mm/yyyy)

Please read carefully the disclaimers at the end of the form.
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* Section 5: Payment details

Do you need us to pay the provider directly? ☐ Yes ☐ No

If 'Yes', we can only make payment to the provider if their bank details are included on the invoice.

Have you personally had to pay costs for the treatment that you are claiming for? ☐ Yes ☐ No

If 'Yes', and you are personally seeking reimbursement, you must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft or cheque', and completing the required information.

If another person or entity has paid on your behalf please give their name:

Please tick one of the following as applicable:

- ☐ Use Recurring Reimbursement Election (RRE) information currently on file
- ☐ Use the bank information provided in this section as your permanent RRE
- ☐ Use the bank information provided below only for expenses related to this claim

Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement, and
- incurring additional bank charges

☐ **1. Bank transfer – this is the quickest and safest method of payment**

Name of account holder: _____

If the patient's name (as given in Section 1) is different to the account holder name, please provide the following details:

Address of account holder: _____

_____

E-mail address of account holder:

Telephone number of account holder: _____

Relationship to the claimant: _____

Bank account details:

Bank name: _____

Bank address (including town/city and country): _____

_____

BIC/SWIFT code: _____ Payment currency: _____

Currency of bank account: _____

Account number: _____

To help us direct your payments efficiently, supply the following as relevant:

IBAN (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks): _____

Routing code/Branch code (as available): _____

ABA number (mandatory for transfers to US located banks): _____

☐ **2. Foreign draft or cheque**

Name to appear on the draft or cheque: _____

Currency of the draft or cheque: _____

Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.

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: _____ Postcode: _____ Country: _____

E-mail: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Date the patient first registered with you/the clinic/the hospital (dd/mm/yyyy): _____

2. Symptoms

a) Provide full details of the symptoms presented: _____

_____

b) Has the patient suffered from the same or similar symptoms before? ☐ Yes ☐ No

If 'Yes', are the symptoms related to a previously diagnosed medical condition? ☐ Yes ☐ No

If 'Yes', specify the medical condition: _____

3. Diagnosis

Diagnosis of medical condition, if known: _____ ICD10 code: _____

Is there any underlying cause? ☐ Yes ☐ No

If 'Yes', provide details: _____

Is the medical condition as a result of an accident? ☐ Yes ☐ No

If 'Yes', was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident? ☐ Yes ☐ No

Treatment proposed: _____

Investigations requested, if any: _____

_____

In your opinion, is this condition: ☐ Acute ☐ Chronic ☐ Acute episode of a chronic condition

4. Type of alternative treatment recommended, if relevant

☐ Physiotherapy ☐ Osteopathic ☐ Chiropractic ☐ Homeopathic ☐ Acupuncture ☐ Traditional Chinese medicine

☐ Ayuverdic ☐ Podiatry Number of sessions needed: _____

5. Referrals

a) Was the patient referred to you? ☐ Yes ☐ No

If 'Yes', please complete the following:

Name of referring practitioner: _____ Date of referral (dd/mm/yyyy): _____

Qualifications: _____ Phone: _____

b) Have you referred the patient? ☐ Yes ☐ No

If 'Yes', provide the following details:

Name of specialist you referred the patient to: _____

Date of referral (dd/mm/yyyy): _____ Phone: _____

Please provide a copy of the referral letters.

6. Hospital admission

Has the patient been admitted to hospital for this condition? ☐ Yes ☐ No

If 'Yes', provide the following details:

Admission date (dd/mm/yyyy): _____ Discharge date (dd/mm/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 (dd/mm/yyyy): _____ Practice stamp: _____

Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.

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 general 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 Claims Procedures.

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.

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

(Continued)

How to complete this form *(continued)*

- 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 or 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 or 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 or 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 Assets Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions

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 Member 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 Limited (Singapore Branch)
  112 Robinson Road
  #09-01 Robinson 112
  Singapore, 068902
  Singapore

- For the quickest and most convenient way of submitting your claim, please register for the secure member website at www.aetnainternational.com and submit your claim online.
- Send your claim via e-mail with copies of your reciepts and all required documents from your medical practitioner, as explained above, to: AsiaPacServices@aetna.com

Contact us.

- For claim related queries please contact our 24 hour Member Services helpline at: Free from Singapore 1-800-723-1241
  Collect or Direct +44-203-788-3290

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Important: This is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.

Please read carefully the disclaimers at the end of the form.
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