aetna®

Claim Form for Dental Treatment Reimbursements

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]: ____________________

* Section 3: Claim details

Detail the symptoms/dental condition that the patient received treatment for: ____________________

Is this claim for a dental checkup? ☐ Yes ☐ No If 'Yes', Section 6 does not need to be completed.

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 dental 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 organization within the Aetna group, its suppliers, providers and any affiliates.

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

* 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 claimant'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:

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: ______

Section 6: Dental treatment – must be completed by the dental practitioner

1. Contact and registration details

Name of dental practitioner: ______________________

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 to you: ______________________

____

b) Provide full details of the clinical findings on examination and note them on the chart below:

Dental chart								**Permanent teeth**									
Treatment																	
Finding																	
Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw
Lower jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw
Finding																	
Treatment																	

Dental chart					**Deciduous teeth**						
Treatment											
Finding											
Upper jaw	55	54	53	52	51	61	62	63	64	65	Upper jaw
Lower jaw	45	44	43	42	41	71	72	73	74	75	Lower jaw
Finding											
Treatment											

Finding:

b = bridge
c = crown
ca/da/dn = caries/decay/ dental necrosis
cl = calculus
g = gap closure
gb = gingival bleeding
gi = gingivitis
gs = gingival swelling
i = implant
in = inlay
m = missing tooth
p = periodontis
pu/od = pulpitis or odontitis

Treatment:

AF = amalgam filling
CF = composite filling
D = denture
E = extraction
I = implant
IN = inlay
M = metal ceramic crown
NB = new bridge
NC = new crown
O = orthodontics
ON = onlay
OR = oral radiograph
PR = panoramic radiograph
RB = replacement bridge
RC = replacement crown
RCT = root canal treatment
S&P = scale and polish

c) Are the symptoms related to a previously diagnosed dental/gum/orthodontic condition? ☐ Yes ☐ No

If 'Yes', specify the dental/gum/orthodontic condition: ______________________

d) On what date did the patient first notice symptoms of the dental condition (dd/mm/yyyy)? ______________________

e) On what date did the patient first present these symptoms to you (dd/mm/yyyy)? ______________________

3. Diagnosis

____

____

____

(continued)

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

Section 6: Dental treatment – must be completed by the dental practitioner (continued)

4. Breakdown of costs

Invoice reference	**Treatment** (include the number of surfaces if any restoration was done and the number of canals if any RCT was done)	**Invoice amount** (including currency)

5. Declaration

I declare that to the best of my knowledge and belief the information given in this section of the Claim form is full, true and complete.

Dental practitioner's signature: ______________________________

Date (dd/mm/yyyy): ____________________ Practice stamp:

How to complete this form

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

Assessment of the claim may be delayed if the patient/main member and the patient's dental practitioner 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 dental practitioner unless the claim is for:

- a routine dental checkup

For any other type of claim, we understand that it may not always be possible to have Section 6 completed by the dental practitioner. 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 dental condition treated
- treatment date
- type of treatment including the tooth number, number of surfaces if restoration work was done and/or number of canals if Root Canal Treatment was done, and
- the dental provider's official stamp

We may need to contact the patient's dental practitioner for more 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, and
- a copy of the investigative tests results where relevant (e.g. x-rays, scans).

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)

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 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 (UK) 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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If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

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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.