aetna

Claim Form for Medical Treatment Reimbursements

For the quickest way of submitting your claim, log into Health Hub at www.aetnainternational.com and submit your claim online.

How to complete this form

One form must be completed for each claimant, for each medical condition treated. Please complete clearly in BLOCK CAPITALS.

Sections 1 to 7 must be completed in full by the claimant or the main member on their behalf, if the claimant is a dependant under the age of 18.

Section 8 must be completed by the medical practitioner, specialist or therapist if required.

Assessment of the claim may be delayed if all the necessary sections of this form are not completed.

We may need to contact the claimant'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.

For information on how to contact us please refer to the 'Where to send your claim' section on page 5.

Section 1: Claimant details (for whom the claim is for)

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: _____

Section 2: Main member/spouse details (if completing the form on behalf of the claimant)

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 (if applicable): _____

[1] as shown on your Member ID Card.

Section 3: Contact details for this claim

Correspondence address: _____

Town: _____ Postcode: _____ Country: _____

Email

Daytime phone: _____ Evening phone: _____

If you are sending this claim to us through your Broker or Plan Sponsor, and you wish for your claims statement (EOB) to be sent directly to them, please tick the box applicable to you. Broker ☐ Plan Sponsor ☐

Section 4: Claim summary

What symptoms did the claimant have which needed treatment? _____

_____

_____

Confirm the medical condition or diagnosis if known: _____

Section 5: Declaration – the Declaration must be signed by the claimant or the main member/spouse if the claimant 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.

Claimant/main member's/spouse's name & signature:	Date (dd/mm/yyyy)

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

Section 6: Claim details

If the claimant 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.

Is this claim for a general wellness check-up?	☐ Yes	☐ No	If 'Yes', Section 8 does not need to be completed.
Is this claim for optical care?	☐ Yes	☐ No	If 'Yes', Section 8 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 8 does not need to be completed and you must provide the relevant claim number: _____
Is this claim for Outpatient Physiotherapy treatment?	☐ Yes	☐ No	If 'Yes', complete the below if you have had more than 6 sessions of Physiotherapy.
Is this claim for Traditional Chinese Medicine Podiatry, Osteopathy or Chiropractic treatment?	☐ Yes	☐ No	If 'Yes', complete the below if you have had more than 4 Sessions of Traditional Chinese Medicine, Podiatry, Osteopathy or Chiropractic treatment.

Why did you need more treatment and what is your current progress? _____

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

If 'Yes', Section 8 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 claimant 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 claimant'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 claimant 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 7: Payment details

Who are we reimbursing?		
☐ Claimant/Main member	☐ The provider	☐ Another person or entity
Please complete the rest of this section below to tell us how you would like to be paid.	*We can only pay them if their bank details are shown on the invoice. You don't need to fill in the rest of this section.*	*If they paid on your behalf:* Name: _____ Relationship you: _____ If they didn't pay on your behalf but you'd like us to pay them, please tell us the reason why you want us to pay them instead of you, and fill in payee details below.

How would you like to be paid?

☐ Using your current Recurring Reimbursement Election (RRE) information

No further information required

☐ 1. By bank transfer

Account holder name: _____

If the account holder name is different to the names given in Section 1 and 2, tell us their full address and Email. We will not be able to make the payment without this information:

Account holder address: _____

Email

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

Postcode: _____ BIC/Swift code (must be completed): _____

Payment Currency: _____ Bank account currency: _____

Account number: _____ IBAN: _____

Sort code (for UK accounts): _____ Routing code: _____

ABA number (for transfers to U.S located banks): _____

☐ Mark here to use these details as your RRE

☐ 2. By foreign draft or cheque

Account holder name: _____

If the account holder name is different to the names given in Section 1 and 2, tell us their full address and Email. We will not be able to make the payment without this information:

Account holder address: _____

Email

Payment Currency: _____

Please note that banks may not always accept foreign drafts in all currencies.

Section 8: 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: _____

Email: [ ]

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.

Section 9: Further information

How to complete this form

- If you are personally seeking reimbursement, we will only issue payment to:
  - the claimant if they are 18 or over
  - the planholder if the claimant is under 18 and is a dependant under the plan, or
  - the parent or legal guardian named as the primary member, if the claimant 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 this 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.
- 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 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

What to send us

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 if relevant (e.g. blood tests, x-rays, ultrasound, MRI / CT scan/ PET scan, etc.)
- a copy of the physiotherapy or complementary medicine referral by the medical practitioner or specialist if applicable, and
- a copy of the admission and discharge reports for inpatient or daycare admissions.

Where to send your claim

Send us your claim in one of the ways listed below:

- By logging in to your Health Hub at www.aetnainternational.com and submitting your claim online.
- By email to: AsiaPacServices@aetna.com.
- By post to: Aetna Global Benefits Limited (Singapore Branch), 80 Robinson Road, #23-02/03, Singapore 068898

We know you may have questions and we're always here to help. You can call us any time on:
Phone: 1-800-723-1241 (Free from Singapore)
+65-6701-6912 (Collect or Direct)

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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.

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