Claim Form

Aetna Global Benefits®

☐ **Medical*** ☐ **Dental*** ☐ **Vision***

** Refer to your plan documents to verify the coverage(s) that are available through your Plan.*

Please also complete Page 2 of this form.

Please mail or fax completed Claim Form with itemized bills and receipts. A separate claim form is needed for each family member. Please tape small receipts on 8.5 x 11 paper.

Aetna Global Benefits
P.O. Box 30258
Tampa, FL 33630-3258
USA

OR

Aetna Global Benefits
4630 Woodlands Corporate Blvd.
Tampa, FL 33614
USA

Telephone: (800) 231-7729 (outside the USA, via AT&T + access)
(813) 775-0190 (direct or collect outside the USA)

Facsimile: (800) 475-8751 (outside the USA, via AT&T + access)
(813) 775-0625 (inside the USA)

E-mail: agbservice@aetna.com

1. Employee Information

Employer Name/Group Number _____

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

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

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

City _____

State/Province _____ Country _____

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

Employee's Primary E-Mail Address _____

(Email addresses are strongly encouraged in the event additional information is needed 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

If the patient is over the age of 19 and attending school, you must provide verification, such as report cards, tuition statements, etc., once per school year.

3. Summary of Medical, Dental, and Vision 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), member 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**, the patient must always include pre-treatment x-rays and details of the accident.

Dates of Service (mm/dd/yyyy)	Provider's (physician, clinic, hospital) Name and Address (If the Provider's name and address is on receipts, write "see receipts")	Description of Service (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)*

_____

_____

_____

Please Retain A Copy For Your Records

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

5. Summary of Reimbursement – Only one requested method of reimbursement and currency will be honored per claim form request. (Unless otherwise indicated, reimbursements will be made payable to the party to which the payment is sent and will be issued via US$ checks)

Send Payment To: ☐ Employee ☐ Provider

Requested Reimbursement Method:

Method	Country/Currency Type for Reimbursement (i.e., Great Britain / Pounds)
☐ Wire	
☐ Check	
☐ Electronic Funds Transfer (EFT)	Available as follows:

☐ Austria – Euro ☐ Germany – Euro ☐ Norway - NOK (Krone)
☐ Belgium – Euro ☐ Great Britain - GBP (Pound) ☐ Portugal – Euro
☐ Canada - CAD (Dollar) ☐ Greece – Euro ☐ Spain – Euro
☐ Denmark - DKK (Krone) ☐ Ireland – Euro ☐ Sweden - SEK (Krona)
☐ Finland – Euro ☐ Italy – Euro ☐ Switzerland - CHF (Franc)
☐ France – Euro ☐ Netherlands – Euro ☐ United States - US$ (Dollar)

If you elected to be reimbursed in an U.S. dollar check, skip to **Section 7**. All other reimbursement methods, continue with **Sections 5 and 6.**

Please check one of the following (as applicable):

☐ Use the Recurring Reimbursement Election (RRE) information currently on file.
☐ Use the banking information provided in **Section 6** below and the Reimbursement information provided above to establish an RRE.
☐ Update the current RRE information on file with the information provided in **Section 5** above and/or **Section 6** below.
☐ Use the banking information provided in **Section 6** below and the Reimbursement information provided above only for this Benefit Request.

6. Bank Information (Bank information can be obtained by contacting your banking institution.)

Primary Bank – Required if wire transfer or EFT, as available, is your preferred reimbursement method as specified in Section 5.
(AGB can wire or EFT 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).)

Bank Information Is for ☐ Employee ☐ Provider

Bank Name _____

Bank Identification Code/Routing Number _____ Bank ID Code Type _____

☐ S.W.I.F.T./BIC Code ☐ CHIPS UID ☐ Federal ABA ☐ Bank Sort ID Bank Account Number _____

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

Bank Address *(Include Country)* _____

Bank Telephone Number *(Include Country Code)* _____

7. Other Health Coverage/Scheme

Are any family members' expenses covered by another health plan/scheme, Medicare, or any U.S. Federal, U.S. State, National, Social government plan?

☐ Yes ☐ No If "Yes," please complete information below.

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

Family Members Birthdate *(mm/dd/yyyy)* | | | / | | | / | | | | | Gender ☐ Male ☐ Female

Name of other Insurance Company or Type of Insurance _____

8. Authorization (Required)

For All Electronic Deposits: I hereby authorize Aetna Life & Casualty (Bermuda) Ltd., Aetna Life Insurance Company, and any of their affiliated companies ("Aetna") 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, Dental, Vision Authorization. Must be signed and Dated: I authorize all physicians, other health professionals, 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, advise, 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 names 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)* _____

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