



# Claim Form

Aetna International

**Please also complete page 2 of this form.**

Medical\*    Pharmacy\*    Dental\*

\* Refer to your plan documents to verify the coverage available through your plan.

Please mail or fax the completed Claim Form with itemized bills and receipts. A separate Claim Form is needed for each family member. Please tape small receipts on a full size sheet of paper.

Aetna International  
PO Box 30545  
Tampa, FL 33630-3548

Telephone: + 1-866-949-6027 (toll-free)  
+ 1-813-775-0034 (collect)  
Facsimile: +1-860-262-9111 (direct dial)  
Email: AmericasServices@aetna.com

## 1. Subscriber Information

Policy Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_  
*(First Name, Middle Initial, Last Name/Surname as displayed on Aetna ID Card)*

Identification Number *(Use the number specified on your Aetna card)*

Subscriber's Birthdate *(mm/dd/yyyy)*   /   /      Gender  Male  Female

Street \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_

Country \_\_\_\_\_ Postal Code \_\_\_\_\_

Subscriber's Telephone Number *(Include Country Code)* \_\_\_\_\_

Subscriber's Primary Email Address \_\_\_\_\_  
*(Email addresses are strongly encouraged if we need additional information 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

Report cards, tuition statements and other forms of school attendance verification may be required once per school year, if your plan includes eligibility guidelines that require school attendance as a condition of coverage for dependents in excess of a specific age. See your plan documents for additional details.

## 3. Summary of Medical, Pharmacy and Dental 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), you 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, you must always include pre-treatment x-rays and details of the accident.

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

\_\_\_\_\_

\_\_\_\_\_

Plans and programs are underwritten or administered by Aetna Life & Casualty (Bermuda) Ltd.

**Please Retain a Copy for Your Records**

Subscriber's Name \_\_\_\_\_  
(First Name, Middle Initial, Last Name/Sumame)

**5. Your Aetna plan of benefits includes the option of claim reimbursements in a variety of currencies and disbursement methods. Establish your selected option in the sections below. Aetna reserves the right to issue the benefit reimbursement in the mode of payment available for the currency type, as circumstances dictate.**  
If you elect reimbursement in a U.S. dollar check, skip to **Section 6**. Continue with **Sections 5, 6 and 7** for all other reimbursement methods.  
Please check one of the following (as applicable):  
 Use the Recurring Reimbursement Election (RRE) information currently on file.  
 Use the information provided in section 6 and/or 7 to establish an RRE.  
 Update the current RRE information on file with the information provided in Section 6 and/or Section 7.  
 Use the information provided in section 6 and/or 7 only for expenses related to this claim form.

**6. Summary of Reimbursement – Only one method of reimbursement and currency will be honored per claim form.**

Send Payment To: <input type="checkbox"/> Subscriber <input type="checkbox"/> Provider	
<b>Requested Reimbursement Method</b>	<b>Country/Currency Type for Reimbursement (i.e., Great Britain / Pounds) If the currency you have elected is not available for the method requested, we will default reimbursement to US (\$).</b>
<input type="checkbox"/> Funds Transfer (Preferred) <b>The most efficient method of transferring funds. Please check with your bank for help with providing the appropriate instructions to us.</b>	
<input type="checkbox"/> Check (Go to section 8)	

**7. Bank Information**

**Primary Bank – Required if funds transfer, as available, is your preferred reimbursement method as specified in Section 5. (We can transfer 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).) The following information is required if you have elected funds transfer as your preferred method for reimbursements.**  
Bank Account Number \_\_\_\_\_  
Name of Accountholder (As it appears on the Bank Statement) \_\_\_\_\_  
Bank Identification Code/Routing Number \_\_\_\_\_  
 S.W.I.F.T./BIC Code (wire only)  CHIPS UID  Federal ABA  Bank Sort ID  IBAN\*  Other \_\_\_\_\_  
\*The IBAN is mandatory for bank transfer claim payment transactions in certain countries, such as the United Arab Emirates (UAE). This must be supplied if you are using a bank account in one of these countries. Members should check with their bank to confirm any IBAN requirements.  
Bank Name \_\_\_\_\_  
Bank Address (Include Country) \_\_\_\_\_  
Bank Telephone Number (Include Country Code) \_\_\_\_\_

**8. Other Health Coverage/Scheme**

Are any family members' expenses covered by another health plan/scheme, National, Social government, Medicare or any U.S. Federal or U.S. State plan?  Yes  No If "Yes," complete the information below.  
Name and Relationship of the Family Member \_\_\_\_\_  
(First Name, Middle Initial, Last Name/Sumame)  
Family Member's Birthdate (mm/dd/yyyy) [ ][ ] / [ ][ ] / [ ][ ][ ][ ] Gender  Male  Female  
Name of other Insurance Company or Type of Insurance \_\_\_\_\_

**9. Authorization (Required)**

**For All Electronic Deposits:** I hereby authorize Aetna Life & Casualty (Bermuda) Ltd. 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, Pharmacy, and Dental Authorization. Must be signed and Dated:** I authorize all physicians, other health professionals, pharmacies/pharmacists, 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, advice, 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 named 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) \_\_\_\_\_

Plans and programs are underwritten or administered by Aetna Life & Casualty (Bermuda) Ltd.

**Please Retain a Copy for Your Records**

## **For Plans Compliant with United States Federal Affordable Care Act (ACA) legislation**

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)