Claim Form

Aetna Global Benefits®

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

Please also complete Page 2 of this form.

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

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 a full size sheet of paper.

Aetna Global Benefits/Aetna
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USA

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+1-859-425-3363 (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

Street _____

City _____ State/Province _____

Country _____ Postal/Zip Code _____

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

Report cards, tuition statements & 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, 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 all dental claims (other than preventive services, e.g. oral exams, x-rays, cleanings, fluoride, etc), complete the Dentist's Statement (GC-14423) and attach to this claim form. Be sure to identify the related tooth number for all dental procedures and include extraction dates or original placement date and reason for replacement of denture or bridge 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, 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)*

_____

_____

Please Retain A Copy For Your Records

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

5. Summary of Reimbursement - Your Aetna Global Benefits (AGB) 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. AGB reserves the right to issue the benefit reimbursement in the mode of payment which is available for the currency type, as circumstances dictate.

If you elect to be reimbursed in a U.S. dollar check, skip to **Section 8**. All other reimbursement methods continue with **Sections 5, 6 and 7.**
Please check one of the following (as applicable) - if left unchecked we will observe for this claim submission only:

☐ Use the Recurring Reimbursement Election (RRE) information currently on file.
☐ Use the information provided in **Sections 5** and/or **6** to establish an RRE.
☐ Update the current RRE information on file with the information provided in **Sections 5** and/or **6**.
☐ Use the information provided in **Sections 5** and/or **6** only for expenses related to this claim form.

Summary of Reimbursement (Method/Currency Type) – Only one method of reimbursement and currency will be honored per claim form. (Unless otherwise indicated, reimbursements will be made via US$ check and payable to the party to which payment is sent.)

Use the information provided below to send any applicable reimbursement payment to: ☐ Employee ☐ Provider

Requested Reimbursement Method	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$.
☐ Funds Transfer (Preferred) **The most efficient method of receiving your benefits reimbursement is via Funds Transfer. Please check with your bank for help with providing the appropriate instructions to AGB.**	
☐ Check	(Complete the Country/Currency and go to **Section 8**.)

6. Bank Information

Primary Bank –The following information is required if you have elected Funds Transfer as your preferred method for reimbursements. AGB will transfer funds to your bank at no cost to you; however, we encourage you to check with your bank to determine any additional fees your bank may charge you for receiving Funds Transfer(s).

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 _____
Bank Name _____
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, Pharmacy, Dental, and Vision 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.

You may elect to use an electronic form of signature on this claim form confirming your verification and declaration to the details given above. For the avoidance of doubt such electronic signature will be valid and binding as if you had provided your original signature. We may rely on such electronic signature as a binding verification and declaration confirming that the information above is accurate and not misleading in all respects.

Patient's or Authorized Person's Signature _____ Date *(mm/dd/yyyy)* _____

Please Retain A Copy For Your Records