



Aetna International Claim Form

Aetna International 理赔申请表

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

每一名家庭成员需要单独一份理赔申请表，表中须列明所有就诊疾病。

Please complete the claim form with Claimant's signature, you also need to provide the below materials:

请完整填写理赔申请表并签名，并提供以下材料：

- Original invoice (Fapiao) and charge breakdown (Medicines, exams, treatments and other expenses)
医疗原始发票及费用清单（药费、检查费、治疗费和其他费用）
- Complete medical records, including but not limited to Outpatient medical record, medical prescription, exam report. Please submit discharge summary if it is an inpatient claim.
完整的病历资料，包括但不限于门诊病历、药品处方及医学检查报告。住院提供出院小结复印件
- A copy of the payee's valid passport/ID card if the claim amount is over RMB10,000, USD 1,000 or equivalent.
若索赔金额高于1万元人民币或外币等值1千美元，需提供收款人的有效身份证正反面/护照复印件。

Please note Aetna International is not responsible for any costs associated with the completion of this form or for any further information/document requested by Us to assess Your claim. The issuing of this Claim Form is in no way an admission of liability.

Aetna International将不承担与本申请表填写或者我们为评估您索赔所要求的任何其他信息/文件所产生的任何相关费用。提供本理赔申请表不代表我们以任何方式承认任何责任。

1. Patient Information – Must be completed 就诊人信息（必须填写）

Policyholder Name 投保人名称	_____	Policy Number 保单编号	_____
Patient's Full Name 就诊人全名	_____	Patient's Member ID 会员编号	_____
Patient's Date of Birth 就诊人出生日期	_____	Relationship 与主被保险人关系	Self Spouse Child Other <input type="checkbox"/> 本人 <input type="checkbox"/> 配偶 <input type="checkbox"/> 子女 <input type="checkbox"/> 其他 _____
Does the patient hold any other health insurance? 就诊人是否同时持有了其他健康保险？	No Yes <input type="checkbox"/> 否 <input type="checkbox"/> 是	Other Carrier Name 其他保险运营商名称	_____
Other Insurance Policy Number 其他保险单编号	_____	Policy Holder Name 投保人姓名	_____

Please submit the relevant documents for the details if you get the reimbursement from other insurance for this claim submission.

如果针对本次索赔申请您已经从其他保险商获得赔偿，请提交关于详细信息的有关文件。

If the claim amount is above RMB 10,000, or in case the claim amount is in non-RMB currencies, for any claim amount above USD 1,000 or equivalent, please complete the following information of the payee, otherwise it may result in claim processing delays.

如果索赔金额高于1万元以上或者外币等值1千美元以上的，请务必在下面填写收款人相关信息，否则可能延误理赔的办理。

Type of ID 证件类型	_____	ID Expiration Date (dd/mm/yyyy) 证件有效期（日/月/年）	_____
ID Number 证件号码	_____	Occupation 职业	_____
Nationality 国籍	_____		

2. Contact Information – Must be completed 联系方式（必须填写）

Contact Name 联系人姓名	_____	Email Address 电子邮件地址	_____
Residence or Office Address (please include ZIP code) 住所地或工作单位地址（需含邮政编码）	_____		
Telephone Number 联系电话	_____	Mobile Number 手机号码	_____

3. Declaration – Must be completed 声明（必须填写）

I declare that all information, to the best of my knowledge, provided on this Claim Form is truthful and correct. I also understand that this declaration gives permission to my insurance company and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous Medical Practitioners. I declare and agree that personal information may be collected, held, disclosed, or transferred (worldwide) to any organisation within my insurance company, its suppliers, providers and any affiliates. I declare that I have read and agree to the Data Protection section in the Handbook.

上述各项内容，及本人提供的一切资料，均完全属实。本人授权贵公司或其指定代表向任何第三方获取处理索赔的信息，提供有关本人此次意外或疾病的一切资料及本人既往的健康状况、病历和诊疗资料。本人声明并同意本人的个人信息将会被保险公司，其供应商，其提供者以及其他任何关联公司收集，持有，披露或转移(全球范围内)。本人声明已阅读并同意会员手册中的数据保护部分。

If the chosen settlement currency is not RMB, I authorize my insurance company to purchase foreign exchange for claim reimbursement up to the policy benefit maximum. 如保险金货币选择‘非人民币’，本人委托贵公司办理以所给付的保险金金额为限的购汇业务。

For Direct Billing case or guaranteed case which the medical treatment received in the pre-appointed provider, I hereby authorize the provider or pre-appointed third party to directly bill my insurance company which should make payment of any benefit payable to the provider or pre-appointed third party.

对于发生在事先约定的医疗机构内，针对特定的或保险公司已经事先担保的医疗服务项目，我授权该医疗机构或指定的第三方代表我向保险公司提出理赔，保险公司将直接付款至该医疗机构或指定的第三方。

Patient's/applicant's Signature _____ **Date** _____
就诊人/申请人签名 _____ **日期** _____

(If patient is under 18 years of age, Parent or Guardian must sign, and signer must be our insured member.)

(如果就诊人不足18周岁，须由就诊人父母一方或监护人签字，且签字人必须为被保险人)

4. Summary of Payment Details – Must be completed 付款信息概述 (必须填写)

Recurring Reimbursement Election 付款信息使用方式:

Receive future payments using the details provided below 通过以下具体信息收取未来付款

Use the payment details that we already have on file for you 使用我们已经为您备案的付款信息

Please indicate your preferred payment currency (If treatment was received in mainland China, RMB policy can only be reimbursed in RMB and USD policy can only be reimbursed in USD. If none is indicated, the default currency of RMB policy is RMB and the default currency of USD policy is USD.)

请说明您首选的付款货币 (如果在大陆境内接受治疗, 人民币保单只能赔付人民币, 而美金保单只能赔付美金。如果没有具体说明, 人民币保单默认货币将为人民币, 而美金保单默认货币将为美金)

RMB bank account 人民币帐户 Non-RMB bank account 非人民币帐户

Account Name Account Number/IBAN Number
 银行账户持有人姓名: _____ 银行账号/IBAN 帐号: _____

Bank Name & Branch Name BIC Code / Swift / Routing / ABA / IFSC
 银行名称 (含支行名称): _____ BIC 编码 / Swift / Routing / ABA / IFSC: _____

Bank Address (include Country)
 银行地址 (包括国家): _____

5. Claim Information 索赔信息

Dates of Services 医疗服务日期	Provider's (physician, clinic, hospital, pharmacy, dentist) Name and Address (If the provider's name and address is on receipts, write "see receipts") 服务提供者 (医生、诊所、医院、药店、牙医) 的名称/姓名和地址 (如果收据上有服务提供者的名称/姓名和地址, 请填写“见收据”)	Description of Service/ Name of Medication/ Device (If hospital, state Inpatient, Day Case or Outpatient) 服务明细/药品/设备名称 (如果在医院治疗, 请说明是住院治疗、日间留院或者门诊治疗)	Diagnosis (Reason for visit) 诊断 (就诊原因)	Country of Claim 费用发生国家	Currency of Claim 发生费用的货币	Total Charge 收费总额

6. Medical Information 医疗信息 (To be completed by Provider, not necessary if medical certificate is submitted 由医疗服务提供者填写, 如提交病历则无须填写)

1. Details of Medical Condition or Diagnosis
 疾病症状或诊断 _____

2. Underlying Cause
 主要病因 _____

3. When did the symptoms first arise (dd / mm / yyyy)
 症状初次发现时间 (日/月/年) _____

4. Is further treatment required? Yes No
 是否需要继续治疗? 是 否
 If yes, please provide treatment plan or others
 如果需要, 请提供诊疗计划或其他补充信息 _____

5. If this visit included diagnostic procedures, other treatments or medicines, please provide results, reports or prescriptions
 如果就诊内容包括检查、治疗或者配药, 请提供相应的诊断结果、报告或者处方 _____

医生签名 Practitioner's Signature 公章 Official Stamp

日期(日/月/年) Date(dd/mm/yyyy)

电话 Telephone

电邮 Email

7. How to submit a Claim 如何提交理赔申请

<ul style="list-style-type: none"> Postal Submission Aetna (Shanghai) Enterprise Services Co., Ltd., Attn: Claim Dept. Suite 702, Gopher Center, 757 Meng Zi Road, Huangpu District, Shanghai 200023 Tel: please refer to the number at the back side of your membership card. 	<ul style="list-style-type: none"> 邮递至 安态 (上海) 企业服务有限公司 理赔部(收) 上海市黄浦区蒙自路 757 号歌斐中心 702 室, 邮编 200023 电话: 请参照会员卡背面电话号码
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保单由您的保单文件中载明的保险公司签发并由安态(上海)企业服务有限公司提供管理服务。安态(上海)企业服务有限公司是 Aetna Inc. 的全资控股子公司。安态(上海)企业服务有限公司隶属于 Aetna Inc. 国际业务部 Aetna International. Aetna® 是 Aetna Inc. 的注册商标并在全球范围内受商标注册条约的保护。

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 请保留副本以作记录 Please Retain a Copy for Your Records