Aetna International Claim Form

Please submit this 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. Failure to complete all sections of this form may result in claim processing delays.

☐ Medical ☐ Dental ☐ Maternity ☐ Vision ☐ Wellness

Please refer to your policy documents to verify the cover available through your Plan.

Important Note: Please ensure Your Claim Form is completed in full and returned within 180 days of the treatment date.

1. Member Information – Must be completed.

Policy Name _____ Policy Number _____

Member's Name _____

Member's Date of Birth _____ Member Aetna Identification Number _____

Street Address _____

City _____ State/Province _____

Country _____ Postal/ZIP Code _____

Member's Telephone Number _____ Mobile Number _____

Member's E-Mail Address _____

2. Patient Information – Must be completed.

Patient's Full Name _____

Patient's Date of Birth _____ Patient's Aetna Identification Number _____

Gender ☐ Male ☐ Female Relationship ☐ Self ☐ Spouse ☐ Child ☐ Other _____

3. Other Health Insurance Coverage – Must be completed.

Do you hold any other insurance? ☐ No ☐ Yes Other Carrier Name _____

Other Insurance Policy Number _____ Policy Holder Name _____

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

4. Claim Information (Please include diagnosis or reason for treatment for each service received.)

- For services related to an accidental injury, details of the accident must be provided.
- For conditions that have required long term treatments, please provide details of when the symptoms and/or treatment began.
- Claims for prescribed drugs or medication should include a prescription from your general practitioner (GP) or medical specialist.
- Acupuncture, Podiatry, Chiropractic, Osteopath, Homeopath treatment and physiotherapy require a referral from your GP or medical specialist.
- If you have insufficient space in any section, please provide full details on separate sheet.

Dates of Services	Provider's (physician, clinic, hospital, pharmacy, dentist) Name and Address (If the provider's name and address is on receipts, write "see receipts")	Description of Service/ Name of Medication/ Device (If hospital, state Inpatient, Day Case or Outpatient)	Diagnosis (Reason for visit)	Country of Claim	Currency of Claim	Total Charge

If the claim is for Maternity please indicate the expected due date of the pregnancy.

_____

Please confirm if your pregnancy is a result of assisted conception/infertility treatment.

_____

For dental claims, please indicate the related tooth and ensure itemized breakdown of services is included.

_____

_____

Were your injuries caused by an Accident? ☐ No ☐ Yes

If Yes, is it: Motor Vehicle Related? ☐ No ☐ Yes, provide Accident Date _____ Time _____ ☐ AM ☐ PM

Work Related? ☐ No ☐ Yes, provide Accident Date _____ Time _____ ☐ AM ☐ PM

Please provide accident details on a separate sheet.

Member's Name (For faxing purpose) : _____

5. Summary of Payment Details – Must be completed.

Recurring Reimbursement Election – Please check one of the following options if you want to:

☐ Receive future payments using the details provided below
☐ Use the payment information provided below for this claim only
☐ Use the payment details that we already have on file for you

Payment Information

Please select your preferred reimbursement method: ☐ Bank Transfer ☐ Cheque
(If no selection is made, the default method is Cheque issued in the member's name.)

Please indicate your preferred payment currency (If none is indicated, the default currency is US Dollar.) _____

Payee Name _____ Specify if: ☐ Member ☐ Provider ☐ Employer

Claim Settlement Address (if different to **Section 1**):

_____
Street

_____ _____ _____
City State/Province Country

If you have selected Bank Transfer as your preferred payment method, the following information is required:

Bank Account Holder Name (as per Bank Statement) _____

Bank Account Number _____ Sort Code/Branch Code _____

IBAN Code* _____ Swift/BIC Code _____

IFSC/ABA/ US Routing Code _____

Bank Name _____

Bank Address (include Country) _____

Bank Telephone Number (include Country Code) _____

*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..

The most efficient method of receiving your benefits reimbursement is via Bank Transfer. Please check with your bank for help with providing the appropriate instructions to Aetna International.

6. Declaration – Must be completed.

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 organization within the Aetna group, its suppliers, providers and any affiliates.

Patient's Signature _____ **Date** _____
(If patient is under 18 years of age, Parent or Guardian must sign.)

Important Note: Please ensure Your Claim Form is completed in full and returned within 180 days of the Treatment date. Failure to complete your form in full will result in the form being returned to you and will delay the processing of your claim. 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.

Please refer to your Member Handbook under General Claims Information for In-Patient, Day-Patient, Out-Patient Treatment and Pre-authorizations for all MRI and CT scans.

7. Additional Information

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_____

How to submit a Claim

Aetna International provides alternative methods of submitting a claim form to make it easier for our members, below are the listed options:

- Postal Submission
  PT Aetna Global Benefits Indonesia
  Menara BCA 50/F. Jl. MH Thamrin No 1, Jakarta
  10310, Indonesia
- Online Claim Submission for our members via our secure portal
  www.aetnainternational.com
- Submit your claim via Fax attaching receipts and referrals from your Medical Practitioner
  +62 21 2358 4723
- Email Submission with copies of your receipts and referrals from your Medical Practitioner
  AsiaPacServices@aetna.com
- For claim related queries please contact our 24 hour Member Services helpline
  +001 803 1 006 0716 (Toll Free from Indonesia)
  +852 3071 5022