Claim Form for Dental Treatment Reimbursements

Please complete clearly in BLOCK CAPITALS.

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

The sections marked by an asterisk (*) must be completed in full by the patient, or the main member on behalf of the patient if the patient is a dependant under the age of 18. Assessment of the claim may be delayed if all the necessary sections of this form are not completed.

Further information about how to complete this form can be found on pages 4-5.

* Section 1  Main member/claimant details

<table>
<thead>
<tr>
<th>Title</th>
<th>Mr</th>
<th>Mrs</th>
<th>Miss</th>
<th>Ms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family name (surname):</td>
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<td></td>
<td></td>
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<tr>
<td>First name:</td>
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<tr>
<td>Date of birth (mm/dd/yyyy):</td>
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<tr>
<td>ID number (as shown on your Aetna card, it could be 6 or 8 digits):</td>
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<td>ID number (as shown on your Aetna card):</td>
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<tr>
<td>Group name:</td>
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<tr>
<td>Correspondence address:</td>
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<tr>
<td>Town:</td>
<td>Country:</td>
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<td>Postcode:</td>
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<td>Email:</td>
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<tr>
<td>Daytime phone:</td>
<td>Evening phone:</td>
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</tbody>
</table>

* Section 2  Patient details (if different from section 1)

<table>
<thead>
<tr>
<th>Title</th>
<th>Mr</th>
<th>Mstr</th>
<th>Mrs</th>
<th>Miss</th>
<th>Ms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family name (surname):</td>
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<td></td>
</tr>
</tbody>
</table>

* Section 3  Claim details

Detail the symptoms/dental condition that the patient received treatment for:

Is this claim for a routine dental checkup?  Yes  No  If ‘Yes’, Section 6 does not need to be completed.

Provide the breakdown of the invoices being submitted with this claim:

<table>
<thead>
<tr>
<th>Country of treatment</th>
<th>Date of treatment</th>
<th>Invoice date</th>
<th>Invoice reference</th>
<th>Invoice amount (including currency)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Use a separate sheet if you need more space.

Total number of invoices:

Does the patient have another insurance plan or policy that covers dental costs?  Yes  No  If ‘Yes’, provide the other insurer’s details including the name of the insurer, the insurer’s address and the patient’s plan or policy number with that insurer:

Is the claim as a result of an accident?  Yes  No  If ‘Yes’, provide the circumstances of the accident including how it happened, the location, the time and the date, using a separate sheet if you need more space:

If the patient has suffered an injury as the result of an accident, are they claiming from a third party?  Yes  No  If ‘Yes’, provide the other insurer’s details including the name and the plan number below:
* Section 4 Declaration – the Declaration must be signed by the patient or the main member if the patient is a dependant under the age of 18

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/main member's signature: __________________________ Date (mm/dd/yyyy): __________________________

* Section 5 Payment details

Do you need us to pay the provider directly?  
☐ Yes  ☐ No

If ‘Yes’, we can only make payment to the provider if their bank details are included on the invoice.

Have you personally had to pay costs for the treatment that you are claiming for?  
☐ Yes  ☐ No

If ‘Yes’, and you are personally seeking reimbursement, you must tell us how you wish to be reimbursed by ticking either 1, ‘Bank transfer’ or 2, ‘Foreign draft / Cheque’, and completing the required information.

If another person or entity has paid on your behalf please give their name: __________________________

Please tick one of the following as applicable.

☐ Use Recurring Reimbursement Election (RRE) information currently on file
☐ Use the bank information provided in this section as your permanent RRE
☐ Use the bank information provided below only for expenses related to this claim

Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity:
• experiencing delays in receiving the claim settlement; and
• incurring additional bank charges.

☐ 1. Bank transfer – this is the quickest and safest method of payment

Name of account holder: __________________________

If the claimant's name (as given in Section 1) is different to the account holder name, please provide the following details

Address of account holder: __________________________

Email address of account holder: __________________________

Telephone number of account holder: __________________________

Relationship to the claimant: __________________________

Bank account details

Bank name: __________________________

Bank address (including town/city and country): __________________________

BIC/SWIFT code: __________________________

Payment currency: __________________________

Currency of bank account: __________________________

Account number: __________________________

To help us direct your payments efficiently, supply the following as relevant

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN): __________________________

Sort code (mandatory for UK located banks): __________________________

Routing code/Branch code (as available): __________________________

ABA number (mandatory for transfers to US located banks): __________________________

☐ 2. Foreign draft / cheque

Name to appear on the draft / cheque: __________________________

Currency of the draft / cheque: __________________________
Section 6 Dental treatment – must be completed by the dental practitioner

1. Contact and registration details

Name of dental practitioner: ____________________________
Qualifications: ______________________________________
Tax Identification Number (required for providers practising in the US): __________________________
Phone: __________________ Fax: ___________________
Address: __________________ Town: ___________________
Country: __________________ Postcode: __________________
Email: ____________________________________________

Date the patient first registered with you/the clinic/the hospital (mm/dd/yyyy): __________________________

2. Symptoms

a) Provide full details of the symptoms that the patient presented to you: ____________________________

b) Provide full details of the clinical findings on examination and note them on the chart below:

<table>
<thead>
<tr>
<th>Finding</th>
<th>Permanent teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper jaw 18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28</td>
<td></td>
</tr>
<tr>
<td>Lower jaw 48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Finding</th>
<th>Deciduous teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper jaw 55 54 53 52 51 61 62 63 64 65</td>
<td></td>
</tr>
<tr>
<td>Lower jaw 45 44 43 42 41 71 72 73 74 75</td>
<td></td>
</tr>
</tbody>
</table>

Finding: b = bridge  g = gap closure  in = inlay
c = crown  gi = gingivitis  m = missing tooth
da/ad/dn = caries/decay/dental necrosis  gs = gingival swelling  p = periodontis
dl = calculus  i = implant  pu = pulpitis
c) Are the symptoms related to a previously diagnosed dental/gum/orthodontic condition?  Yes  No
If ‘Yes’, specify the dental/gum/orthodontic condition: ____________________________
d) On what date did the patient first notice symptoms of the dental condition (mm/dd/yyyy)? ____________________________
e) On what date did the patient first present these symptoms to you (mm/dd/yyyy)? ____________________________

3. Diagnosis

__________________________

4. Treatment

Complete the dental chart by using the abbreviations below

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<tbody>
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<td></td>
</tr>
</tbody>
</table>

Treatment:
AF = amalgam filling  M = metal ceramic crown  PR = panoramic radiograph
CF = composite filling  NB = new bridge  RB = replacement bridge
D = denture  NC = new crown  RC = replacement crown
E = extraction  O = orthodontics  RCT = root canal treatment
I = implant  ON = onlay  S&P = scale and polish
IN = inlay  OR = oral radiograph

(continued)
Section 6 Dental treatment – must be completed by the dental practitioner (continued)

5. Breakdown of costs

<table>
<thead>
<tr>
<th>Invoice reference</th>
<th>Treatment (include the number of surfaces if any restoration was done and the number of canals if any RCT was done)</th>
<th>Invoice amount (including currency)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

6. Declaration

I declare that to the best of my knowledge and belief the information given in this section of the Claim form is full, true and complete.

Dental practitioner’s signature: [Signature]

Date (mm/dd/yyyy): [Date]

Practice stamp

How to complete this form

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

Assessment of the claim may be delayed if the patient/main member and the patient’s dental practitioner do not complete all the necessary sections of this form.

Sections 1 to 5 must be completed by the patient or the main member on behalf of the patient if the patient is a dependant under the age of 18.

Section 6 must be completed by the patient’s dental practitioner unless the claim is for:

- a routine dental checkup.

For any other type of claim, we understand that it may not always be possible to have Section 6 completed by the dental practitioner. In such circumstances, we will process the claim if the invoices and receipts for the treatment costs incurred contain all of the following:

- diagnosis of the dental condition treated;
- treatment date;
- type of treatment including the tooth number, number of surfaces if restoration work was done and/or number of canals if Root Canal Treatment was done; and
- the dental provider’s official stamp.

We may need to contact the patient’s dental practitioner for more information in order for us to process the claim under the terms and conditions of the policy. We will tell you if we need to do this.

A quick guide on how to submit your claim. For detailed information, please refer to the “Your guide to making a claim” section in your Member Handbook.

Send us the claim within 180 days of the first treatment date. You must send the following items to make sure that we can process your claim:

- the fully completed Claim form;
- the original itemised invoice;
- the original receipt. We do not accept credit card statements as proof of payment;
- a copy of the prescription if you are claiming for medication; and
- a copy of the investigative tests results where relevant (e.g. x-rays, scans).

Important information

Please remember these important points when completing your Claim form.

Section 3 – Claim details

If the patient has another insurance plan or policy that covers him/her for medical costs, we will need to know the details as it may affect the amount we pay in respect of their claim.

Section 4 – Declaration

If the declaration has not been read and signed, we will not be able to process the claim.
Section 5 – Payment details

- If you are not personally seeking reimbursement we will pay the treatment provider directly, as long as the payment instructions are shown clearly on the invoice.
- If you are personally seeking reimbursement, we will only issue payment to:
  - the patient if they are 18 or over;
  - the plan holder if the patient is under 18 and is a dependant under the plan; or
  - the parent or legal guardian named as the primary member, if the patient is under 18.
- Ensure that you are able to receive payment in the method and currency you have requested.
- We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or recipient bank service charges. Please contact your bank for further details.
- If you do not give us the sort code/routing code, BIC/ SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.
- Payment by foreign draft / cheque in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft / cheque. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the base currency of your plan. For the current list of applicable currencies and countries please refer to our website.
- We cannot issue non-QAR foreign drafts/cheques to members/providers with bank accounts based in Qatar as the banks will not allow those to be encashed.
- Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.
- Whenever coverage provided by any insurance policy is in violation of any U.S, U.N or EU economic or trade sanctions, such coverage shall be null and void. For example, Aetna companies cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more on the US Treasury’s website at: www.treasury.gov/resource-center/sanctions.

We know you may have questions and we’re always here to help. You can call us any time on the phone number listed on the back of your Aetna ID Card.

You can also send us a secure email by logging in to www.aetnainternational.com and clicking ‘Contact us’

You can scan your claims to us, rather than post them. It is important that any claim you send to us is done either by scan or originals, but not both.
Section 7  Data Protection

Aetna Global Benefits (UK) Limited (‘Aetna’, ‘we’) is the data controller of personal data collected and processed for the purposes set out in this document. Aetna considers personal data or personal ‘information’ to be confidential. We protect the privacy of that information in accordance with applicable privacy laws and regulations, as well as our own company privacy policies.

These laws and regulations include, but are not limited to, the Health Insurance Portability and Accountability Act Privacy Rules (HIPAA Privacy Rules), the General Data Protection Regulation (GDPR), the UK Data Protection Act 2018 and any applicable EU member state legislation and derogations.

We will use your personal data to determine eligibility and provide a quotation to you or to your broker; onboarding you to the plan, process payments, premiums and claims; managing, administering and improving your policy; investigating and responding to complaints; contact you with information about your plan and for the purposes of providing healthcare or wellness advice; fraud prevention together with any other regulatory checks; establish, exercise or defend legal claims or rights and to protect, exercise and enforce our rights, property or safety.

Where your health data is used for any of the above we rely on the insurance condition provided under the UK Data Protection Act 2018, which means we don’t need to acquire your consent for the processing.

We retain your personal data for as long as necessary to provide you the benefits under your insurance plan, until such time as any claim under the insurance policy is concluded, until the limitation for exercising any legal rights has expired or for compliance with any legal or regulatory requirements.

We may disclose information about you in various ways, including, but not limited to: health care operations, treatment, disclosure to other covered entities, plan administration, research, business associates, industry regulation, law enforcement, legal proceedings and public welfare.

In all situations other than those described above, we will ask for your written authorization before using or disclosing information about you.

We will not send any personal data or health information outside the EEA unless the appropriate protections are in place, or unless there are emergency medical ground for doing so.

To help us make sure that your personal information remains accurate and up-to-date, please inform us of any changes.

You have the right to access to your personal information, to request correction, erasure, restriction of processing, transfer of your information, and object to the processing of your personal data.

If you would like to exercise any of your rights relating to your personal data, or enquiry any further information, please contact our designated Data Protection Officer:

Data Protection Officer
50 Cannon Street,
London EC4N 6JJ
United Kingdom
Or
dpo@aetna.com

You can find our full terms and conditions and details of our privacy policy at https://www.aetnainternational.com/en/about-us/legal-notices.html

Send your claim to

- For the quickest and most convenient way of submitting your claim, please register for the secure member website at www.aetnainternational.com and submit your claim online.
- Send your claim via fax attaching receipts and all required documents from your medical practitioner, as explained above, to: +44 870 442 4387
- Send your claim via email with copies of your receipts and all required documents from your medical practitioner, as explained above, to: EuropeServices@aetna.com
- For claim related queries please contact our 24 hour Member Services helpline at: +44 870 442 4386

Plans are underwritten by Aetna Insurance Company Limited, registered in England (Company Registration No. 05956141), which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Firm Reference No. 458505).

Plans are administered on behalf of the insurer by Aetna Global Benefits (Europe) Limited, registered in England (Company Registration No. 04548434), which is authorised and regulated by the Financial Conduct Authority (Firm Reference No. 310030). Both companies are registered at 50 Cannon Street, London, EC4N 6JJ, United Kingdom.

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Aetna does not provide care or guarantee access to health services. Not all health services are covered. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to www.aetnainternational.com.

Aetna companies cannot pay for health services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more at US Treasury’s website at www.treasury.gov/resource-center/sanctions.