Aetna International

aetna[®] 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 memb	per/claimant details	i		
Title 🗌 Mr 🗌 Mrs 🗌 Mis	s 🔲 Ms		Family name (surname	e):
First name:			Middle name:	
Date of birth (mm/dd/yyyy):			Gender 🗌 Male 🗌	Female
ID number (as shown on your <i>i</i>	Aetna card, it could be	6 or 8 digits):		
Policy number (as shown on yo	our Aetna card):			
Group name:				
Correspondence address:				
Town:			Country:	
Postcode:				
Email:				
Daytime phone:			Evening phone:	
	ails (if different from			
Title 🗌 Mr 🗌 Mstr 🗌 Mr				e):
First name:				
ID number (as shown on your /	Aetna card, it could be	6 or 8 digits):		
* Section 3 Claim detai		-		
		·		
Detail the symptoms/dental co	idition that the patient	received treatmen	t for:	
Is this claim for a routine denta	l checkup? 🗌 Yes	No If 'Yes', S	Section 6 does not nee	d to be completed.
Provide the breakdown of the i	nvoices being submitte	ed with this claim:		
Country of treatment	Date of treatment	Invoice date	Invoice reference	Invoice amount (including currency)
Use a separate sheet if you r	leed more space.			Total number of invoices:
Does the patient have another	insurance plan or polic er's details including th	-		Total number of invoices:] No ess and the patient's plan or policy
Does the patient have another If 'Yes', provide the other insur- number with that insurer:	insurance plan or polic er's details including th	ne name of the insu] No
Does the patient have another If 'Yes', provide the other insur number with that insurer: 	insurance plan or polic er's details including th ccident?	No	urer, the insurer's addre] No ess and the patient's plan or policy
Does the patient have another If 'Yes', provide the other insur number with that insurer: 	insurance plan or polic er's details including th ccident?	No	urer, the insurer's addre] No
Does the patient have another If 'Yes', provide the other insur- number with that insurer: Is the claim as a result of an ac If 'Yes', provide the circumstan	insurance plan or polic er's details including th ccident?	No	urer, the insurer's addre] No ess and the patient's plan or policy
Does the patient have another If 'Yes', provide the other insur- number with that insurer: Is the claim as a result of an ac If 'Yes', provide the circumstan	insurance plan or polic er's details including th ccident? Yes cces of the accident inc	No No No No No No No No No No No No No N	vened, the location, the] No ess and the patient's plan or policy time and the date, using a separate

* Se	ction 4	Declaration – the Declaration – the Declaration				st b	e si	gneo	l by i	the	pati	ien	t or	r th	eı	ma	in	me	em	be	r if	the) pa	atie	nt i	is a
Aetna repre the n inform	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.																									
Patie	ent's/main n	nember's signature:																	D	ate	(m	m/d	d/y	ууу)	:	
																			1			_				
* Se	ction 5	Payment details																								
-		to pay the provider direc only make payment to th	•					etails	are ir	ncluc	led o	on t	he i	nvc	pice	€.										
lf 'Ye	s', and you	nally had to pay costs for are personally seeking r oreign draft' / 'Cheque', a	eimbu	irsem	ient,	you i	must	tell u	Is ho	v yo	u wi] N eim		se	d b <u>i</u>	y tio	ckir	ng e	eithe	er 1,	, 'Ba	ank	
If and	other perso	n or entity has paid on yo	our bel	half p	leas	e giv	e the	eir na	ne:																	
□ □ Failu	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:																									
	Name of ac If the clain details	nsfer – this is the quickes count holder: nant's name (as given i account holder:								cou	nt h	old	er n	nam	ıe,	ple	eas	e p	oro	vid	e th	ne fo	ollo	owin	ıg	
	Telephone Relationshi Bank acco Bank name	ess of account holder: number of account holde p to the claimant: unt details :: ess (including town/city a																								
	Payment or Currency o Account nu To help us IBAN numb Sort code (Routing co	code:	efficie /ments d bank able):	ently, s to b (s): _	sup ank a	ply t acco	he fe	ollow in co	ing a untrie	s re	leva at ha	ant ave	ado	opte	ed I	BA	N):									
	Name to ap	draft / cheque opear on the draft / chequ f the draft / cheque:																								

Section 6	D	ental t	reatm	nent -	- must	be co	mp	leted by	the d	ent	al p	racti	itioner							
1. Contact a	nd reg	gistratio	on det	ails																
Name of den	tal pra	actitione	r:																	
Qualification	s:																			
Tax Identifica	ation N	lumber	(requir	ed for	provide	ers prac	ctisin	ng in the L	JS):											
Phone:																				
Address:																				
Country:							-		Pos	tcod	de: _									
Email:																				
	Date the patient first registered with you/the clinic/the hospital (mm/dd/yyyy):																			
2. Symptoma) Provide f		ails of th	ne sym	ptom	s that th	e patie	nt pi	resented	to you:											
b) Provide f	ull det	aile of th	o clini	cal fir	dinas o	n evan	vinat	ion and n	oto the	mo	n th	o cha		r						
Dental chart	uli uel				luings o	ii exaii	iiiiai		maner			e cha		/.						
		1 1		1	1		1	Per	maner		etn							1		
Finding	40	47	10	45	4.4	40	10	4.4	04	00		00	0.4	05	00	07	00			
Upper jaw	18	17	16	15	14	13	12	11	21	22		23	24	25	26	27		28 Upper		
Lower jaw	48	47	46	45	44	43	42	41	31	32		33	34	35	36	37	38	Lowe	Jaw	
Finding								Dec	iduau		ath									
Finding	Dental chart Deciduous teeth																			
Upper jaw		55	54 53		53	52		51	61		62		63	64		65	Upperiow			
Lower jaw		45	44		43	42		41	71		72		73	74		75		Upper jaw Lower jaw		
Finding		40			-10						12		10	14		10	2000	Jaw		
Finding																				
b = bridge					g	= gap	clos	ure					in =	inlay						
c = crown					g	i = ging	giviti	s					m =	: missi	ng too	th				
ca/da/dn = ca	aries/c	lecay/de	ental n	ecrosi				I swelling					•	period						
cl = calculus c) Are the s	vmnto	ma rola	had to	0 0100		= impla		lontol/aur	n/ortho	don	tio o	onditi		· pulpit						
lf 'Yes', s										uun		onulli				NU				
d) On what			•						l condi	tion	(mn	n/dd/v	/////							
e) On what																				
3. Diagnosis				1				, ,			,,,,	,,								
o. Diagnosis	,																			
4. Treatmen	t																			
Complete the	e denta	al chart l	by usiı	ng the	abbrev	iations	belc	w												
Dental chart								Per	maner	nt te	eth									
Finding																				
Upper jaw	18	17	16	15	14	13	12	11	21	22		23	24	25	26	27	28	Upper	iaw	
Lower jaw	48	47	46	45	44	43	42	41	31	32		33	34	35 36		37	38	Lower	-	
Finding																				
Dental chart								Dec	iduou	s te	eth				•			•		
Finding																				
Upper jaw		55	54		53	52		51	61		62		63	64		65	Upper jaw			
Lower jaw		45	44		43	42		41	71		72		73		74		Lowe	_ower jaw		
Finding																				
Treatment:																				
AF = amalga								al cerami	c crow	n				•		ic radio	• •			
CF = compos	site fill	ing						w bridge								nent brid				
D = denture							w crown							•	nent cro					
E = extractio I = implant	r1							odontics								nal treat				
IN = inlay							ON = onlay S&P = scale and polish OR = oral radiograph													

Section 6 Dental treatment – must be completed by the dental practitioner (continued)							
5. Breakdown of costs							
Invoice reference	Treatment (include the number restoration was done and the r RCT was done)	Invoice amount (including currency)					
6. Declaration							
I declare that to the best of my know	ledge and belief the information gi	iven in this section of the Clai	m form is full, true and complete.				
Dental practitioner's signature:							
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.

How to complete this form *(continued)*

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: <u>www.treasury.gov/resource-center/sanctions</u>.

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 <u>https://www.aetnainternational.com/en/about-us/legal-notices.html</u>

Send your claim to

By post: Aetna Global Benefits (Europe) Limited	 For the quickest and most convenient way of submitting your claim, please register for the secure member website at <u>www.aetnainternational.com</u> and submit your claim online.
25 Templer Avenue IQ Farnborough, Farnborough, Hampshire. GU14_6FE,	 Send your claim via fax attaching receipts and all required documents from your medical practitioner, as explained above, to: +44 870 442 4387
United Kingdom	 Send your claim via email with copies of your reciepts and all required documents from your medical practitioner, as explained above, to: <u>EuropeServices@aetna.com</u>
	 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 <u>www.AetnaInternational.com</u>.

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 <u>www.treasury.gov/resource-center/sanctions</u>.