



Première Healthcare Plan Claim Form

Aetna Global Benefits®

Please ensure **Your** Claim Form is completed in full and returned within six months of **Your** initial **Treatment**. Failure to complete **Your** form in full will result in the form being returned to **You** and will hold up the processing of **Your** claim. Please note Aetna Global Benefits is not responsible for any costs associated with the completion of this form or for any further information/documents requested by **Us** to assess **Your** claim. The issuing of this Claim Form is in no way an admission of liability.

If You have insufficient space in any section, please provide full details on separate sheet.

You will need to send ALL Claim Forms together with the schedule of amounts paid by the CPAM and any other original documentation to support **Your** Claim to:

Première Administration Services
37, rue Anatole
F-92300 Levallois Perret
France

T: +33 (0) 1 77 68 01 64
F: +33 (0) 1 77 68 01 68
E: AGBPremiereClaims@aetna.com

Policyholder Information

Policyholder Name	Policy Number
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Section A: Patient's Details – To be completed by the member.

1. Family Name		
2. First Name and Initials	3. Date of Birth (Day/Month/Year)	
4. Address		
5. Contact Telephone Number	6. Fax/Mobile	7. Email
8. Do You hold any other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please provide full details on a separate sheet.</i>		9. Were Your injuries caused by an Accident ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please provide full details on a separate sheet.</i>

Section B: Claim Reimbursement – To be completed by the member. It is essential that all information is completed if **We** are to complete an international transfer.

Please check one of the following (as applicable):

i) Please pay Doctor/**Treatment** Provider.

ii) **Bank Transfer to payee below:**

Use the bank details on file to send an **electronic funds transfer**.

Use the bank details below for this claim only.

Use the bank details below for all future claim reimbursements until further notice.

Bank Details - the following information is required in full. AGB will transfer funds at no cost to You however, We encourage You to check with Your bank regarding additional fees they may pass on to You for these transactions.

Please complete this section in BLOCK CAPITAL LETTERS.

Currency in which **You** wish to be reimbursed: _____

Name of Accountholder (As it appears on the Bank Statement): _____

Bank Account Number (or IBAN): _____

Bank Identification Code/Routing Code: _____

Routing code type: SWIFT/BIC Code CHIPS UID Federal ABA Bank Sort ID Other _____

Bank Name: _____

Bank Address (include Country): _____

Bank Telephone Number (including country code): _____

iii) **Cheque - Payee:** _____ **Currency:** _____

Address to which settlement letter should be sent:

Please Retain a Copy for Your Records

Policies are issued and underwritten or reinsured in Europe by Aetna Health Insurance Company of Europe, Limited, Aetna Life & Casualty (Bermuda) Ltd. and issued and administered by Aetna Global Benefits (Europe) Limited, an Aetna Company and regulated by the Financial Services Authority. Registered address: 76 Shoe Lane, London EC4A 3JB. Registered in England & Wales. Registered No. 04548434.

Section C: Declaration

"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 Aetna Global Benefits 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 the personal information collected or held by Aetna Global Benefits, whether contained in this claims form or otherwise obtained may be used by Aetna Global Benefits, or disclosed to or transferred to any organisation within the Aetna Group (of Companies), their suppliers and partners, Worldwide for the purpose of 1) providing on-going insurance and customer service, 2) processing and giving effect to credit card payment, 3) generating statistics to provide marketing material in respect of insurance-related services of Aetna Global Benefits or it's associated companies and 4) processing claims or analysing the insurance."

Patient's Signature <i>(If patient is under 18 years of age, Parent or Guardian must sign.)</i>	Date (Day/Month/Year)
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Section D: Claims Information – To be completed by the patient's Medical Practitioner or Dental Practitioner.

1. Details of Medical Condition Requiring Treatment : <i>(Please provide the precise diagnosis, if known.)</i>	
2. Underlying Cause	
3. If this claim is for maternity, please advise whether the pregnancy is as a result of any form of assisted conception.	
4. How long has this condition existed?	5. When did the patient first become aware of any symptoms prior to seeking medical Advice ?
6. Date of first consultation with any practitioner for this condition.	7. Has this, or any similar condition previously been suffered from?
8. Please confirm the likely period of Treatment and prognosis (if known):	
9. Name and address of referring Doctor/Dentist <i>(Please complete only if the patient has been referred to You.)</i>	
10. Please detail any diagnostic tests performed and attach the results.	
11. This question relates to Dental Treatment only. Is this claim for a routine check-up? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section E: Medical Practitioner or Dental Practitioner Details – To be completed by the patient's Medical Practitioner or Dental Practitioner.****IMPORTANT** - Please ensure:**

- All original receipts and prescriptions are attached.
- The Claim Form is completed in full.
- The declarations are signed and dated.
- All laboratory tests are attached.
- The diagnosis and underlying cause have been confirmed.

This will ensure that **Your** claim is reviewed in a timely fashion.

Official Stamp:

Name of Practitioner		
Address of Practitioner		
Telephone Number	Fax Number	Email
Practitioner's Signature		Date (Day/Month/Year)

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FOR TREATMENT RECEIVED OUTSIDE FRANCE

Important Note:

Please ensure that all costs for non-**Emergency In-Patient/Day-Patient Treatment**, all MRI and CT scans are agreed by **Us**, via **Our** International Member Service Centre or in writing (fax/email/letter) before any planned **Treatment** is undertaken. Planned **Treatment** undertaken without pre-authorisation from **Us** will not be covered. A verbal confirmation does not constitute pre-approval. If in doubt, please contact the International Member Service Centre, as shown on **Your** membership card.

PLEASE NOTE: A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH CONDITION CLAIMED.

Planned In-Patient and Day-Patient Treatment

In the event of a planned admission on an **In-Patient** or **Day-Patient** basis to a **Hospital**, the following steps must be taken. Payment of all expenses incurred by **You** will not be recoverable unless **You** follow these procedures.

- i) Contact **Our** International Member Service Centre as soon as reasonably possible prior to admission giving full details of the condition, proposed **Treatment** including dates and name of procedure (if known) together with the name of the **Specialist** and **Hospital** details. (The telephone number is provided on the back of **Your** membership card.)
- ii) The International Member Service Centre will advise **You** if they have sufficient information to confirm **Your** cover. If not, they will advise **You** what further information is required.
- iii) When sufficient information has been made available to appraise **Your** claim, the International Member Service Centre will verbally confirm the basis of **Your** cover and will despatch written confirmation to **You**.
- iv) The International Member Service Centre will attempt at all times to make arrangements with the **Hospital** for all eligible bills to be settled directly. Where this has been arranged, **You** should send the original Claim Form and any unpaid invoices (if given to **You** by the **Hospital**) to **Your** Aetna Global Benefits Claims Service.
- v) Please ensure a new/separate Claim Form for each member, each new **Medical Condition** and each admission to **Hospital**, is submitted.

Out-Patient Treatment

If **You** receive medical **Treatment** as an **Out-Patient**, outside of **Our Provider Network**, **Treatment** must be paid for in full by **You** at the time of the appointment and re-claimed from **Us**. In such circumstances, please ensure that a Claim Form is completed by **You** and the **Medical Practitioner** or **Specialist**. Please remit this to **Your** Aetna Global Benefits Claims Service with all substantiating proof of **Your** claim, including but not limited to, the original invoice(s) and proof of payment, prescription and a written diagnosis from the **Medical Practitioner**.

Please Retain a Copy for Your Records

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