



Mobile Healthcare Plan Claim Form

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 a separate sheet.

Please return this completed form to **Us** or **Your** agent.

Aetna Global Benefits
c/o Goodhealth Worldwide (Global) Limited
PO Box 30545
Tampa, Florida 33630
USA

TF: +1 866 545 3252 (inside USA only)
T: +1 813 775 0220
F: +1 860 262 9111
E: AmericasServices@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. E-mail
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>	

Please Retain a Copy for Your Records

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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) **Check - Payee:** _____ **Currency:** _____

Address to which settlement letter should be sent:

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 organization 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 its associated companies and 4) processing claims or analyzing the insurance."

Patient's Signature (If patient is under 18 years of age, parent or guardian must sign.)

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:**

1. All original receipts and prescriptions are attached.
 2. The Claim Form is completed in full.
 3. The declarations are signed and dated.
 4. All laboratory tests are attached.
 5. 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	E-mail
Practitioner's Signature		Date (Day/Month/Year)

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Important Note

The issuing of this claim form is in no way an admission of liability. Failure to complete **Your** form will result in the form being returned to **You**. When **You** are submitting a claim to Aetna Global Benefits, the following guidelines will help to ensure that **You** receive **Your Treatment** as quickly as possible and to avoid any unnecessary delays in reimbursing any costs that **You** may have paid **Yourself**.

Emergency Medical Treatment

In the event of emergency admissions **You** should contact **Your** nearest Emergency Assistance Medical Help-Line listed below or the International Member Service Center as soon as possible prior to or immediately following an **In-Patient** admission.

Important: Please remember that **You** or **Your** representative must contact the International Member Service Center within 24 hours from the date of admission. Failure to do so may result in only 50 percent of any eligible claims being reimbursed.

24-Hour Emergency Assistance Medical Help-Line

Europe + 44 (0)208 762 8129

Hong Kong + 852 2970 3045

Jakarta + 6221 7591 2847

Planned In-Patient and Day-Patient Treatment

In the event of a planned admission to a **Hospital** on an **In-Patient** or **Day-Patient** basis, **We** would ask **You** to take the following steps.

- i) First of all, contact the International Member Service Center on the number as stated on the reverse of **Your** membership card as soon as possible prior to admission, having ready full details about **Your Medical Condition** and proposed **Treatment** (including the dates and name of the procedure if these are known), together with the name of **Your** treating **Specialist** and the **Hospital** where **You** will be treated.
- ii) **Our** International Member Service Center will let **You** know if the information **You** provide is sufficient to confirm **Your** coverage. If not, they will let **You** know what additional information will be required.
- iii) While **Our** Claims Center will verbally confirm **Your** coverage, they will also send **You** written confirmation either by e-mail, fax or post.
- iv) Wherever possible, **We** will aim to make arrangements with **Your Hospital** to settle all eligible bills directly. Where this is arranged, please send **Your** completed form and any unpaid invoices that **You** may have been given as soon as possible to the International Member Service Center that **You** have been speaking with.

Important: Please remember that it is **Your** responsibility to contact the International Member Service Center prior to any planned admission. Failure to do so will result in only 50 percent of any eligible claim being reimbursed.

Out-Patient Treatment

Any medical **Treatment** **You** receive as an **Out-Patient** must be paid for in full by **You** and re-claimed from the International Member Service Center. When submitting any claims for reimbursement, please ensure that:

- **You** complete the first page of the claim form in full detailing each condition treated. **You** must then sign and date the declaration to enable the claim to be validated.
- **You** should attach to **Your** claim form the original paid receipts (or other proof of payment) for all **Treatment** for which **You** are making a claim.
- Where **Your Treatment** has been provided by a registered chiropractor, osteopath, homeopath or acupuncturist, please ensure that **You** attach to **Your** claim form, a copy of the referral letter that was provided by **Your Physician**.
- Where applicable laboratory tests results and/or x-rays were provided, include the test results with **Your** claim.

Please note that any charges that may be made by an attending **Physician** for completing **Your** claim form are not eligible for reimbursement under the terms and conditions of the **Policy** and **You** will be responsible for settling these. If **Your Physician** needs to refer **You** to another **Specialist** (physiotherapy, chiropractic, osteopathic or any other **Specialist Treatment**), please ensure that they give **You** a referral letter, before commencing any further **Treatment**.

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