Direct Billing Medical Claim Form

Please complete clearly in BLOCK CAPITALS.

Section A: Patient details – 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. The Declaration must be signed by the patient or the main member if the patient is a dependant under the age of 18.

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other: _____

Family name (surname): _____ First name(s): _____

Date of birth (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Plan sponsor: _____

Member number: _____ Plan number: _____

Email: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Daytime phone: _____ Evening phone: _____

Symptoms/condition needing treatment: _____

_____

Declaration

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 and the insurer of your plan (if not Aetna) will rely on the information provided as such. I agree and accept that this declaration gives Aetna and the insurer of your plan (if not 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 organisation within the Aetna group, its suppliers, providers and any affiliates.

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

Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.

Section B: Medical information – must be completed by the medical practitioner/specialist/therapist
For Maternity claims complete sections 7 and 8 only.

1. Symptoms

a) Provide full details of the symptoms presented: _____

_____

b) Has the patient suffered from the same or similar symptoms before? ☐ Yes ☐ No

If 'Yes', are the symptoms related to a previously diagnosed medical condition? ☐ Yes ☐ No

If 'Yes', specify the medical condition: _____

c) On what date did the patient first notice these symptoms (dd/mm/yyyy)? _____

d) On what date did the patient first present these symptoms to you (dd/mm/yyyy)? _____

2. Investigations requested, if any

Provide full details: _____

3. Diagnosis

Diagnosis of medical condition, if known: _____ ICD10 code: _____

Is there any underlying cause? ☐ Yes ☐ No

If 'Yes', provide details: _____

Is the medical condition as a result of an accident? ☐ Yes ☐ No

If 'Yes', was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident? ☐ Yes ☐ No

Treatment proposed: _____

In your opinion, is this condition: ☐ Acute ☐ Chronic ☐ Acute episode of a chronic condition

4. Medication prescribed – attach a copy of the prescription note/form

Name of medication: _____

Amount/dosage: _____

5. Type(s) of complementary treatment recommended (please tick)

☐ Physiotherapy ☐ Osteopathic ☐ Chiropractic ☐ Homeopathic ☐ Acupuncture

☐ Chinese medicine ☐ Podiatry Number of sessions needed: ☐

6. Referrals

Has the patient been referred to you? ☐ Yes ☐ No

Name of the referring practitioner: _____

Qualifications: _____

7. Maternity treatment

Date of the patient's LMP (dd/mm/yyyy): _____ How many weeks pregnant is the patient? _____

Is the pregnancy a result of any infertility treatment including infertility medication or conception by artificial means? ☐ Yes ☐ No

Expected type of delivery: ☐ Normal Vaginal Delivery ☐ C-Section

If 'C-Section', advise the reason: _____

Does the patient suffer from any medical conditions that might put the current pregnancy at risk: ☐ Yes ☐ No

If 'Yes', provide details: _____

_____

Is the reason for this visit: ☐ Routine antenatal checkup? ☐ Antenatal complications

If this visit is for 'Antenatal complications' provide details: _____

8. Declaration

I declare that to the best of my knowledge and belief the statements made on this form are full, true and complete..

Medical practitioner's/specialist's/therapist's signature: _____

Date (dd/mm/yyyy): _____ Practice stamp: ☐

Please call us on **+44-203-788-3288** or email **EuropeServices@aetna.com** if you require any further assistance.

Send your claim to: Claims Team, Aetna Global Benefits (UK) Limited, 25 Templer Avenue, IQ Farnborough, Farnborough, Hampshire, GU14 6FE, United Kingdom.

F: +44-870-442-4377

Section C: Data Protection, Access to Medical Reports

We will require additional consent before any medical reports can be released.