Area Presidency

Claims submission made easy

This form can be used to submit a claim for medical, dental or pharmaceutical services.*

(if personal funds were used)*

If you're filing a claim for more than one person, a separate form is needed for each family member.

How to Fill in this Form

- Complete the entire form using black ink
- Mark your answers, where applicable, with an 'X', like this: ☒
- Double check to make sure your payment details are accurate
- Sign and date the authorization
- Write your member identification number on each document submitted with your claim form
- Keep a copy of your completed form for your records

Submitting your claim

Once you have completed the claim form, you'll need to submit it along with your itemized bills and receipts. If your receipts are small, you should tape them on to a full-size piece of paper. Then, submit the documents whichever way you prefer.

- **Email it***
  Send attachments to aiservice@aetna.com
  NOTE: Attachment limit size is 10MB
- **Mail it**
  Aetna International/Aetna. PO Box 981543, El Paso, TX 79998-1543, USA

For Claim Status or Service, Call:
US Direct: +1 813 775 0141, (TTY: 711)

Some services may require additional information

For some services, you'll need to submit additional documents. If your claim falls into any of the categories below, you'll need to provide the additional items listed.

Prosthetic services (such as crowns, bridges or dentures):

- X-rays (or the dentist's narrative report, if x-rays are not available)
- A dental chart showing any missing teeth and dates of extraction
- Date of prior prosthetic placement with a rationale for replacement if applicable

Periodontal services:

- X-rays
- Current dated pre-operative periodontal charting

Orthodontic services:

- Date appliance was placed
- Number of months of treatment
- Number of months of treatment remaining

Services relating to accidental injury

- Pre-treatment X-rays
- Details of the accident

Subscriber's Name (First Name, Middle Initial, Last Name/Surname)

1 Personal details

About the member (Area Presidency)

Name (as shown on your Aetna ID card – including full First name)

First name(s):

Last name/Surname:

Aetna ID number (as shown on your Aetna ID card)

Date of birth (MMDDYYYY)

Gender

☐ Male ☐ Female

Contact details

Telephone number *(include Area &/or Country Code)*:

Email address:

Address

Street Address:

City:

State/province:

Country:

Postal/ZIP code:

2 Reimbursement details

Where would you like reimbursement to be sent?

☒ To the member (Area Presidency)

What payment details should we use to reimburse you?

☒ Use the information provided in the Payment Details section below to establish an RRE (Recurring Reimbursement Election), or update your current RRE

How should we process your reimbursement?

☒ By bank funds transfer from Aetna to the bank account given below. *This is the easiest way of reimbursement.*

What currency would you like to be reimbursed with, i.e. GBP?
If the currency chosen is not available for the reimbursement method selected above, we will default to a US Dollar ($) wire, if bank details are available, or a US Dollar ($) check payable to the party to which payment is sent, if no bank details exist.

Country:

Currency:

Reimbursement for Providers Outside of the U.S.

If, acting reasonably, we determine that any central bank or relevant government or governmental authority imposes an artificial exchange rate (including without limitation an exchange rate which is inconsistent with the free market exchange rate) in relation to a relevant currency for any reason, we may in our sole discretion reimburse you for your valid claims pursuant to this agreement for treatment in such country in any manner we may reasonably decide. In making such determination we shall seek to ensure that, in keeping with the fundamental basis of any contract of insurance, we indemnify you for your loss (subject to the terms and conditions of your policy) but do not unjustly enrich you as may have been the case had we applied such artificial exchange rate to pay you in another currency.

Aetna In-Network Providers Outside the U.S.

The manner of reimbursement may consist of payment in (i) the applicable local currency (if feasible at the sole discretion of Aetna), or (ii) if you do not have a bank account in such local currency, in the currency in which the policy premium was paid in an amount equal to that which we would have paid our **network provider** in the currency in which premium was paid pursuant to our obligations to such **network provider** (as we may reasonably determine), subject in each case to the principle of indemnity we mention above.

About the plan sponsor

Name

The Church of Jesus Christ of Latter-day Saints

Group number (found on the ID card)

About the patient

Name

First name(s):

Last name/Surname:

Date of birth (MMDDYYYY)

Gender

☐ Male ☐ Female

Relationship to member

☐ Self ☐ Spouse ☐ Child ☐ Other:

Out-of-Network Providers Outside the U.S.

The manner of reimbursement may consist of payment in (i) the applicable local currency subject to the principle of indemnity we mention above (if feasible at the sole discretion of Aetna), or (ii) if you do not have a bank account in such local currency, in the currency in which the policy premium was paid in an amount equal to the applicable **Reasonable and Customary Charges**.

Payment details

If you have chosen to receive your benefits by bank transfer, please complete the details below.
We will transfer funds to your bank at no cost to you, but we encourage you to please check with your bank to determine whether your bank may charge you any additional fees for receiving Funds Transfers.

Name of Bank Accountholder (as it appears on Bank Statement)

Bank Account number

Bank Identification Code/Routing number or Alternative ID / Code

☐ S.W.I.F.T./BIC Code (wire only) ☐ CHIPS UID ☐ Federal ABA

☐ Bank Sort ID ☐ IBAN* ☐ Other**

(Please check with your bank to confirm any IBAN requirements, which, in certain countries, are mandatory and must be supplied for bank funds transfer claim payment transactions, such as in the United Arab Emirates (UAE).*

*** Use Other entry field to describe reported Alternative IDs or Codes such as Bank Code/Branch, RUT#, IFSC Code, KBA#*

Bank details

Bank name:

Street address:

City:

State/province:

Country:

Postal/ZIP code:

Telephone number *(include Area &/or Country Code)*:

3 Claim details

What type of service(s) are you filing a claim for? *Refer to your plan documents to verify the coverage(s) that are available through your Plan.*

☐ Medical ☐ Pharmacy ☐ Dental - please attach form GC-14423
(Identify the related tooth number for all dental procedures)

Respond "Yes" or "No"
The claim is related to a work-related accident or condition. ☐ Yes ☒ No

Please note:
Use the space below to summarize each instance of treatment you're filing a claim for. If you need to submit a claim for more than two instances, please also complete Page 3 and return it along with this form.

☐ Check here if only the Treatment Summaries below are included for this claim submission.

Treatment summary

Treatment date (MMDDYYYY)

Total charge (with currency)

Location of claim – Provider's name and address

City:

State/province:

Country:

Postal/ZIP code:

Description of service
i.e. type of treatment, name of medication/device

Reason for visit

Type of patient
☐ Inpatient ☐ Outpatient

If in patient...
What was the admit date? (MMDDYYYY)

And the discharge date? (MMDDYYYY)

Treatment summary

Treatment date (MMDDYYYY)

Total charge (with currency)

Location of claim – Provider's name and address

City:

State/province:

Country:

Postal/ZIP code:

Description of service
i.e. type of treatment, name of medication/device

Reason for visit

Type of patient
☐ Inpatient ☐ Outpatient

If in patient...
What was the admit date? (MMDDYYYY)

And the discharge date? (MMDDYYYY)

Please note:
Use the space below to summarize each instance of treatment you're filing a claim for. If you need to submit a claim for more than the two additional instances (below), please copy this page before you go any further and return any additional sheets along with this form.

Please renumber the Page Numbers of the additional copies beginning with Page 5.

Treatment summary

Treatment date (MMDDYYYY)

Total charge (with currency)

Location of claim – Provider's name and address

City:

State/province:

Country:

Postal/ZIP code:

Description of service

i.e. type of treatment, name of medication/device

Reason for visit

Type of patient

☐ Inpatient ☐ Outpatient

If in patient...

What was the admit date? (MMDDYYYY)

And the discharge date? (MMDDYYYY)

Treatment summary

Treatment date (MMDDYYYY)

Total charge (with currency)

Location of claim – Provider's name and address

City:

State/province:

Country:

Postal/ZIP code:

Description of service

i.e. type of treatment, name of medication/device

Reason for visit

Type of patient

☐ Inpatient ☐ Outpatient

If in patient...

What was the admit date? (MMDDYYYY)

And the discharge date? (MMDDYYYY)

4 Other existing health coverage

Is anyone in your family covered by another health plan or scheme, Medicare, or any US Federal, US State, National or Social government plan?

☒ No →go straight to 6 (Authorization)

5 Consent to Process Health Data

The information you have provided in this claim form contains personal data as well as health data. In order to help you make an informed decision as to whether to provide consent to process your health data, we provide some information below.

Aetna Life & Casualty (Bermuda) Ltd., Aetna Life Insurance Company ('Aetna', 'we') is the data controller of all the data that you have provided with this form, including health data. We protect the privacy of the data contained in this form in accordance with applicable privacy laws and regulations, as well as our own company privacy policies.

We will use the personal data and health data provided with this claim form to assess, process, and administer your claim.

We will retain your personal data and health data for as long as necessary for these purposes, and in addition we may keep claim data for 10 years from date of closure of your claim to meet our legal or regulatory obligations.

We may disclose information about you to third parties for the purposes of assessing, processing and administering your claim. We will remain the controller of the data and will require those third parties to protect your data. The information you provide with this claim form will be processed within the United States, in accordance with the terms of the applicable insurance policy.

For more information on your data privacy rights, and on whom to contact with questions about Aetna's privacy practices, you can view our full privacy policy at **https://www.aetnainternational.com/en/about-us/legal-notices.html**.

Please note that by declining to give your consent, we may not be able to continue with processing your claim or have sufficient information to make a fully informed decision concerning your claim.

6 Authorization

For all electronic deposits

I hereby authorize Aetna Life & Casualty (Bermuda) Ltd., Aetna Life Insurance Company, and any of their affiliated companies ("Aetna") and/or their dedicated Agents to make payments of any benefits payable to me and/or my dependents, by crediting such payments to my account at the bank or financial institution named on this form. I agree to notify Aetna in writing of any changes relating to the information provided on this form or withdrawal of this authorization. I agree that if, for any reason, unearned benefit payments are deposited into my account, I will immediately repay the full amount of any such payments. I further agree that if I do not immediately repay such payments, I will personally be liable for all costs of collection (including reasonable attorney's fees and the maximum interest permitted by law).

Medical, pharmacy, and dental authorization

Must be signed and dated.

I authorize all physicians, other health professionals, pharmacies/ pharmacists, hospitals and health care institutions to provide Aetna and any independent parties acting on Aetna's behalf or with whom Aetna has contracted, information concerning health care, advice, treatment or supplies provided to the Patient (including that related to mental illness and/or AIDS/ARC/HIV). This information will be used for the purposes of evaluating and administering claims. Aetna may provide the plan sponsor named on this form with any benefit calculation used in the payment of this claim for the purpose of reviewing the experience and operation of the policy/contract. This authorization is valid for the term of the policy or contract under which a claim is submitted. I know I have a right to receive a copy of this authorization upon request and agree that a copy of this authorization is as valid as the original.

I further authorize Aetna to process my medical data for the purpose of processing my claim as set forth under Section 5, Consent to Process Claim Data.

Warning: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.

You may elect to use an electronic form of signature on this claim form confirming your verification and declaration to the details given above. For the avoidance of doubt such electronic signature will be valid and binding as if you had provided your original signature. We may rely on such electronic signature as a binding verification and declaration confirming that the information above is accurate and not misleading in all respects.

Patient or Authorized Person's signature

Date Signed (MMDDYYYY)

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

Coverage underwritten by Aetna Life Insurance Company and/or Aetna Life & Casualty (Bermuda) Ltd.

Misrepresentation/Fraud Statement

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

United States Fraud Statements Below:

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California Residents: For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a statement of claim containing any materially **false** information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a **crime**. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law. **Attention Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. **Attention New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Signature _____ **Date** _____