Aetna International Claim Form
Aetna International 理赔申请表

One form must be completed for each patient, for each medical condition treated.
每一名家庭成员需要单独一份理赔申请表，表中须列明所有就诊疾病。

Please complete the claim form with Claimant's signature, you also need to provide the below materials:
请完整填写理赔申请表并签名，并提供以下材料：

- Original invoice (Fapiao) and charge breakdown (Medicines, exams, treatments and other expenses)
  医疗原始发票及费用清单（药费、检查费、治疗费和其他费用）
- Complete medical records, including but not limited to Outpatient medical record, medical prescription, exam report. Please submit discharge summary if it is an inpatient claim.
  完整的病历资料，包括但不限于门急诊病历、药品处方及医学检查报告。住院提供出院小结复印件
- A copy of the payee's valid passport/ID card if the claim amount is over RMB10,000, USD 1,000 or equivalent.
  若索赔金额高于1万元人民币或外币等值1千美元，请提供收款人的有效身份证正反面/护照复印件。

Please note Aetna International is not responsible for any costs associated with the completion of this form or for any further information/document requested by Us to assess Your claim. The issuing of this Claim Form is in no way an admission of liability.
Aetna International将不承担与本申请表填写或者我们为评估您索赔所要求的任何其他信息/文件所产生的任何相关费用。提供本理赔申请表不代表我们以任何方式承认任何责任。

1. Patient Information – Must be completed 就诊人信息（必须填写）

Policyholder Name 投保人名称 _____
Policy Number 保单编号 _____
Patient's Full Name 就诊人全名 _____
Patient's Member ID 会员编号 _____
Patient's Date of Birth 就诊人出生日期 _____
Relationship 与主被保险人关系 ☐ Self 本人 ☐ Spouse 配偶 ☐ Child 子女 ☐ Other 其他 _____
Does the patient hold any other health insurance? 就诊人是否同时持有了其他健康保险? ☐ No 否 ☐ Yes 是
Other Carrier Name 其他保险运营商名称 _____
Other Insurance Policy Number 其他保险单编号 _____
Policy Holder Name 投保人姓名 _____

Please submit the relevant documents for the details if you get the reimbursement from other insurance for this claim submission.
如果针对本次索赔申请您已经从其他保险商获得赔偿，请提交关于详细信息的有关文件。

If the claim amount is above RMB 10,000, or in case the claim amount is in non-RMB currencies, for any claim amount above USD 1,000 or equivalent, please complete the following information of the payee, otherwise it may result in claim processing delays.
如果索赔金额高于 1 万元以上或者外币等值 1 千美元以上的，请务必在下面填写收款人相关信息，否则可能延误理赔的办理。

Patient's name 就诊人姓名 _____
Nationality 国籍 _____
Occupation 职业 _____
Type of ID 证件类型 _____
ID Number 证件号码 _____
ID Expiration Date (dd/mm/yy) 证件有效期 （日/月/年） _____
Mailing address 通讯地址 _____
ZIP code 邮政编码 _____
Mobile number 手机号码 _____

Note 注： For patients' age under 18, please fill in Appendix A. 如果就诊人未满 18 周岁，请完整填写附录 A。

2. Contact Information – Must be completed 联系方式（必须填写）

Contact Name 联系人姓名 _____
Email Address 电子邮件地址 _____
Mobile Number 手机号码 _____

3. Declaration – Must be completed 声明（必须填写）

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 my insurance company 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 personal information may be collected, held, disclosed, or transferred (worldwide) to any organisation within my insurance company, its suppliers, providers and any affiliates. I declare that I have read and agree to the Data Protection section in the Handbook.
上述各项内容，及本人提供的一切资料，均完全属实。本人授权贵公司或其指定代表向任何第三方获取处理索赔的信息, 提供有关本人此次意外或疾病的一切资料及本人既往的健康状况、病历和诊疗资料。本人声明并同意本人的个人信息将会被保险公司，其供应商，其提供者以及其他任何关联公司收集，持有，披露或转移(全球范围内）。本人声明已阅读并同意会员手册中的数据保护部分。

If the chosen settlement currency is not RMB, I authorize my insurance company to purchase foreign exchange for claim reimbursement up to the policy benefit maximum. 如保险金货币选择 '非人民币' ，本人委托贵公司办理以所给付的保险金金额为限的购汇业务。

For Direct Billing case or guaranteed case which the medical treatment received in the pre-appointed provider, I hereby authorize the provider or pre-appointed third party to directly bill my insurance company which should make payment of any benefit payable to the provider or pre-appointed third party.
对于发生在事先约定的医疗机构内，针对特定的或保险公司已经事先担保的医疗服务项目，我授权该医疗机构或指定的第三方代表我向保险公司提出理赔，保险公司将直接付款至该医疗机构或指定的第三方。

Patient's/applicant's Signature 就诊人/申请人签名 _____ **Date 日期** _____

(If patient is under 18 years of age, Parent or Guardian must sign, and signer must be our insured member.)
(如果就诊人不足 18 周岁，须由就诊人父母一方或监护人签字，且签字人必须为被保险人)

请仔细阅读表格最后列示的免责申明 Please read carefully the disclaimers at the end of the forms
请保留副本以作记录 Please Retain a Copy for Your Records

4. Summary of Payment Details – Must be completed 付款信息概述（必须填写）

Recurring Reimbursement Election 付款信息使用方式:

☐ Receive future payments using the details provided below 通过以下具体信息收取未来付款

☐ Use the payment details that we already have on file for you 使用我们已经为您备案的付款信息

Please indicate your preferred payment currency (If treatment was received in mainland China, RMB policy can only be reimbursed in RMB and USD policy can only be reimbursed in USD. If none is indicated, the default currency of RMB policy is RMB and the default currency of USD policy is USD.)
请说明您首选的付款货币（如果在中国大陆境内接受治疗，人民币保单只能赔付人民币，而美金保单只能赔付美金。
如果没有具体说明，人民币保单默认货币将为人民币，而美金保单默认货币将为美金）

☐ RMB bank account 人民币帐户 ☐ Non-RMB bank account 非人民币帐户

Account Name
银行账户持有人姓名: _____

Account Number/IBAN Number
银行账号/IBAN 帐号: _____

Bank Name & Branch Name
银行名称 (含支行名称)： _____

BIC Code / Swift / Routing / ABA / IFSC
BIC 编码 / Swift / Routing / ABA / IFSC: _____

Bank Address (include Country)
银行地址（包括国家）： _____

5. Claim Information 索赔信息

Dates of Services 医疗服务日期	**Provider's (physician, clinic, hospital, pharmacy, dentist) Name and Address (If the provider's name and address is on receipts, write "see receipts")** 服务提供者（医生、诊所、医院、药店、牙医）的名称/姓名和地址（如果收据上有服务提供者的名称/姓名和地址，请填写"见收据"）	**Description of Service/ Name of Medication/ Device (If hospital, state Inpatient, Day Case or Outpatient)** 服务明细/药品/设备名称（如果在医院治疗，请说明是住院治疗、日间留院或者门诊治疗）	**Diagnosis (Reason for visit)** 诊断（就诊原因）	**Country of Claim** 费用发生国家	**Currency of Claim** 发生费用的货币	**Total Charge** 收费总额

6. Medical Information 医疗信息 (To be completed by Provider，not necessary if medical certificate is submitted 由医疗服务提供者填写，如提交病历则无须填写)

1. Details of Medical Condition or Diagnosis
   疾病症状或诊断 _____
2. Underlying Cause
   主要病因 _____
3. When did the symptoms first arise (dd / mm / yyyy)
   症状初次发现时间 （日/月/年） _____
4. Is further treatment required? ☐ Yes ☐ No
   是否需要继续治疗? ☐ 是 ☐ 否
   If yes, please provide treatment plan or others
   如果需要，请提供诊疗计划或其他补充信息 _____
5. If this visit included diagnostic procedures, other treatments or medicines, please provide results, reports or prescriptions
   如果就诊内容包括检查、治疗或者配药，请提供相应的诊断结果、报告或者处方

医生签名 Practitioner's Signature	公章 Official Stamp
日期(日/月/年) Date(dd/mm/yyyy)	
电话 Telephone	
电邮 Email	

7. How to submit a Claim 如何提交理赔申请

- Postal Submission 邮递至:
  Aetna (Shanghai) Enterprise Services Co., Ltd., Attn: Claim Dept. A09, 35F, Ping An Riverfront Financial Center, 757 Mengzi Road, Shanghai 200023 Tel: please refer to the number at the back side of your membership card.安态（上海）企业服务有限公司 理赔部(收)
  上海市黄浦区蒙自路757号平安滨江金融中心35楼A09室，邮编 200023 电话：请参照会员卡背面电话号码

微信线上理赔 Claim via WeChat

请仔细阅读表格最后列示的免责申明 Please read carefully the disclaimers at the end of the forms

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