Questions?
We know you may have questions and we're always here to help. You can call us any time on the phone number listed on the back of your Aetna ID Card.

You can also send us a secure e-mail by logging in to **www.aetnainternational.com** and clicking 'Contact us'.

Claims submission Instructions

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

- All the sections starting with M must be completed. Failure to complete the sections may result in claim processing delays.
- 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 (Section 6)
- 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, please submit it along with your itemized bills and receipts. Please attach bills and receipts onto an A4 page if it is smaller than a full size. Submit the documents to us within 180 days from the treatment date using one of the methods below:

- Upload it*
  Log-in at www.aetnainternational.com **and click 'Claims Center'**
- Fax it
  +852-2866-2555
- E-mail it*
  Send attachments to AsiaPacServices@aetna.com
- Mail it
  Aetna Global Benefits (Asia Pacific) Limited
  Suite 401-403 DCH Commercial Centre
  25 Westlands Road, Quarry Bay, Hong Kong

** Attachment limit size is 10MB*

Check List of general claims (Out/Day/In Patient)

Claim Form	√
Bill / Receipt / Payment Proof	√
Medical Information(especially diagnosis)&	√
Cost Breakdown of Service*	√

& ***Provided by separated medical reports/ records, discharge summary, Section 4 or Section 5 of claim form.***

* ***Please ask for it from your treating medical practitioner if it is not provided to you directly.***

Points about other information required

- Please refer to your benefit schedule and member handbook for detailed claim guidelines.
- The below requirements are based on the standard benefit terms. Should there be any discrepancies between this document and the member handbook please refer to the handbook for complete detail.

Vision Care:

- The Optometric prescription
- The lens power of the vision hardware purchased
- The volume & usage of contract lenses purchased

Services relating to accidental injury:

- Relevant medical report (e.g. X-Ray)
- Details of the accident

Prescribed drugs or Medication:

- A prescription from your general practitioner or medical specialist

Alternative treatment or physiotherapy

- A referral letter from your general practitioner or medical specialist.
- A progress report from a specialist after the initial 10 sessions is required for physiotherapy.

Please note:
All the sections starting with M must be completed. Failure to complete the sections may result in claim processing delays.

1 Personal details

About the patient

M Name (as shown on your Aetna ID card)

First name(s):

Last name/Surname:

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

M Date of birth (M M D D Y Y Y Y)

Gender ☐ Male ☐ Female

M Contact details

The e-mail or postal address provided will be used to send your EOB (Explanation of Benefit).

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

E-mail address:

Street Address:

City:

State/province:

Country:

Postal/ZIP code:

About the policy

M Policy Number(as shown on your Aetna ID card)

Policy Holder Name (as shown on your Aetna ID card)
For **Group Policies** only

2 M Other existing health coverage

Do you hold any other health plan or scheme, Medicare, or any US Federal, US State, National or Social government plan?

☐ No

☐ Yes – please continue with this section

Name of other insurance company

Policy Number

Policy Holder Name

Please submit the relevant documents of claim explanation if you get the reimbursement from other insurance for this claim submission.

3 Reimbursement details

M The full name of payee who receive the claim reimbursement

M What currency would you like to be reimbursed with?

If none is indicated, the default currency is **USD**

☐ USD ☐ SGD ☐ HKD ☐ IDR ☐ CNY

☐ Others

M How should we process your reimbursement?

☐ By bank transfer – Please complete Section A below
This is the easiest way of reimbursement.

☐ By cheque– Please complete Section B below

Section A (By bank transfer)

We will transfer the payment to your bank at no cost to you, but we encourage you to please check with your bank to determine if any additional fees apply.

☐ Use the bank information provided below

☐ Use the bank information that we already have on file for you

Name of Bank Account holder (as it appears on Bank Statement)

Bank Account number

Bank Identification Code/Routing number

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

☐ Bank Sort ID ☐ IBAN ☐ Others

Bank name:

Bank address:

How should we send your EOB (Explanation of Benefit)?

☐ By the e-mail address provided in 'Contact Details' of Section 1

☐ By the post address provided in 'Contact Details' of Section 1

Section B (By cheque)

Please complete this section if the address is different from 'Contact Details' of Section 1.Your EOB (Explanation of Benefit) will be to the same address as your cheque.

Street Address:

City:

State/province:

Country:

Postal/ZIP code:

Please note:

- **If you need to submit more than two claims for one person, please make copies of this page and submit it with this form.**
- **All the sections starting with M must be completed. Failure to complete the sections may result in claim processing delays.**

4 M Claim details

Claim summary

Date of service

M M D D Y Y Y Y

Claimed Amount (with currency)

☐ Check here if the details have been provided by your treating practitioner in Section 5. Proceed to Section 6.

Type of Claim

☐ Dental ☐ Maternity ☐ Vision ☐ Wellness

☐ Medical – please continue with this section

Diagnosis / Underlying cause (Important Information)

e.g., gastroenteritis, Hypertension, etc.

When did the symptoms and/or treatment begin for the condition that required long term care?

Description of service

e.g. type of treatment, name of device

Location of claim – Provider's name and address

If the provider's name and address are on the receipts, write "see receipts"

Name:

Address:

Claim summary

Date of service

M M D D Y Y Y Y

Claimed Amount (with currency)

☐ Check here if the details have been provided by your treating practitioner in Section 5. Proceed to Section 6.

Type of Claim

☐ Dental ☐ Maternity ☐ Vision ☐ Wellness

☐ Medical – please continue with this section

Diagnosis / Underlying cause (Important Information)

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Description of service

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Location of claim – Provider's name and address

If the provider's name and address are on the receipts, write "see receipts"

Name:

Address:

Please note:

- **All the sections starting with M must be completed. Failure to complete the sections may result in claim processing delays.**

5 Medical Information(Optional)

Please note:

- You can make use of the following section for scenarios where:
  - **a)** Medical report/discharge summary for in-patient treatment is not available
  - **b)** Referral letter for Acupuncture, Podiatry, Chiropractic, Osteopath, Homeopath or physiotherapy treatment is not available
  - **c)** If you have any difficulty in completing Section 4 of this form and need the assistance from your treating medical practitioner
- This section needs to be completed by your treating medical practitioner
- It is recommended that you take this form with you during your visit and have the medical practitioner to complete this section
- We may request for addition information should the information provided is insufficient to complete our assessment

Patient's chief complaint/Doctor's impression

Diagnosis / Underlying cause

When did the symptoms first arise?

Details of treatment provided

For in-patient,

What was the admission date? And the discharge date?

M M D D Y Y Y Y M M D D Y Y Y Y

Is further treatment required?

☐ No ☐ Yes – Provide the treatment Plan

Other supplementary information

Name of Medical Practitioner

Title of Medical Practitioner

Contact information of Medical Practitioner

Address:

Telephone:

E-mail:

Signature of Medical Practitioner

Date signed

M M D D Y Y Y Y

6 M Authorization

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 will rely on the information provided as such. I agree and accept that this declaration gives 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 organization within the Aetna group, its suppliers, providers and any affiliates.

Patient or Authorized Person's signature

(If patient is under 18 years of age, Parent or Guardian must sign.)

Date signed

M M D D Y Y Y Y