aetna℠

AI WorldTraveler℠ Claim Form

☐ **Medical** ☐ **Pharmacy**

Aetna International
Please also complete Page 2 of this form.

Please mail or fax completed Claim Form with itemized bills and receipts. A separate Claim Form is needed for each family member. Please tape small receipts on a full size sheet of paper.

Aetna International/Aetna
PO Box 981543
El Paso, TX 79998-1543
USA

Telephone: +1-877-301-5042 (outside the USA, via AT&T + access)
+1-813-775-0239 (direct or collect outside the USA)

Facsimile: +1-800-475-8751 (outside the USA, via AT&T + access)
+1-860-975-1741 (inside the USA)

E-mail: aiservice@aetna.com

1. Employee Information

Employer Name/Group Number 299440-

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

Identification Number ☐☐☐☐☐☐☐☐☐☐☐

(*Aetna assigned upon receipt of initial claim, or refer to the Explanation of Benefits (EOBs) from previous AI WorldTraveler claim submissions.*)

Employee's Birthdate *(mm/dd/yyyy)* ☐☐/☐☐/☐☐☐☐ Gender ☐ Male ☐ Female

Street _____

City _____ State/Province _____

Country _____ Postal/ZIP Code _____

Employee's Telephone Number *(Include Country Code)* _____

Employee's Home Country _____ Dates of Travel _____

Employee's Primary E-Mail Address _____
(E-mail addresses are strongly encouraged in the event additional information is needed to process your claim.)

2. Patient Information

Patient's Name *(First Name, Middle Initial, Last Name/Surname)* _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient's Birthdate *(mm/dd/yyyy)* ☐☐/☐☐/☐☐☐☐ Gender ☐ Male ☐ Female

3. Summary of Medical and Pharmacy Services (Please include diagnosis or reason for treatment for each service received.)

Dates of Service (mm/dd/yyyy)	Provider's (physician, clinic, hospital, pharmacy) Name and Address (If the Provider's name and address is on receipts, write "see receipts")	Description of Service/ Name of Medication/ Drug/Device (If hospital, indicate inpatient or outpatient)	Diagnosis (Reason for visit)	City/State/ Province/Country of Claim	Currency of Claim	Total Charge

4. Claim Information

If Yes is answered to either question below, **c** and **d** in this section must be completed.

a. Is the claim related to a work related accident or condition? ☐ Yes ☐ No

b. Is the claim related to an accidental injury? ☐ Yes ☐ No

c. Accident Date *(mm/dd/yyyy)* ☐☐/☐☐/☐☐☐☐ Time _____ ☐ AM ☐ PM

d. Description of Accident *(How and Where)*

_____

_____

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

5. Summary of Reimbursement (Method/Currency Type) – Only one method of reimbursement and currency will be honored per claim form. (Unless otherwise indicated, reimbursements will be made via US$ check and payable to the party to which payment is sent.)

Use the information provided below to send any applicable reimbursement payment to: ☐ Employee ☐ Provider

Requested Reimbursement Method	Country/Currency Type for Reimbursement (i.e., Great Britain / Pounds) If the currency you have elected is not available for the method requested, we will default reimbursement to US$.
☐ Funds Transfer (Preferred) **The most efficient method of receiving your benefits reimbursement is via Funds Transfer. Please check with your bank for help with providing the appropriate instructions to AI.**	
☐ Check	(Complete the Country/Currency and go to **Section 8**.)

6. Bank Information

Primary Bank –The following information is required if you have elected Funds Transfer as your preferred method for reimbursements. AI will transfer funds to your bank at no cost to you; however, we encourage you to check with your bank to determine any additional fees your bank may charge you for receiving Funds Transfer(s).

Bank Account Number _____

Name of Accountholder *(As it appears on the Bank Statement)* _____

Bank Identification Code/Routing Number _____

☐ S.W.I.F.T./BIC Code (wire only) ☐ CHIPS UID ☐ Federal ABA ☐ Bank Sort ID ☐ IBAN ☐ Other _____

Bank Name _____

Bank Address *(Include Country)* _____

Bank Telephone Number *(Include Country Code)* _____

7. Other Health Coverage/Scheme

Are any family members' expenses covered by another health plan/scheme, Medicare, or any U.S. Federal, U.S. State, National, Social government plan? ☐ Yes ☐ No If "Yes," please complete information below.

Name and Relationship of the Family Member _____
(First Name, Middle Initial, Last Name/Surname)

Family Members Birthdate *(mm/dd/yyyy)* | | | / | | | / | | | | | Gender ☐ Male ☐ Female

Name of other Insurance Company or Type of Insurance _____

8. Authorization (Required)

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 and Pharmacy 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 employer 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.

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 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's or Authorized Person's Signature _____ Date *(mm/dd/yyyy)* _____

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