



# Claim Form

Aetna Global Benefits®

**Please also complete Page 2 of this form.**

Medical\*  Pharmacy\*  Dental\*  Vision\*

\* Refer to your plan documents to verify the coverage(s) that are available through your Plan.

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 Global Benefits<br>P.O. Box 30258<br>Tampa, FL 33630-3258<br>USA | OR | Aetna Global Benefits<br>4630 Woodland Corporate Blvd.<br>Tampa, FL 33614<br>USA | <b>Telephone:</b> +1-800-231-7729 (outside the USA, via AT&T + access)<br>+1-813-775-0190 (direct or collect outside the USA) |
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|  |    |  | <b>E-mail:</b> <a href="mailto:agbservice@aetna.com">agbservice@aetna.com</a>   |

## 1. Employee Information

Employer Name/Group Number \_\_\_\_\_  
 Employee's Name \_\_\_\_\_  
*(First Name, Middle Initial, Last Name/Surname as displayed on Aetna ID Card)*

Identification Number *(Use the number specified on your AETNA ID card)*

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 Primary E-Mail Address \_\_\_\_\_  
*(Email 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

Report cards, tuition statements & other forms of school attendance verification may be required once per school year, if your plan includes eligibility guidelines that require school attendance as a condition of coverage for dependents in excess of a specific age. See your plan documents for additional details.

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

- **For prosthetic services** (crowns, bridges or dentures) the following information must be supplied:
  - The x-rays. (If x-rays are not available, provide the dentist's narrative report.)
  - For all dental claims (other than preventive services, e.g. oral exams, x-rays, cleanings, fluoride, etc), complete the Dentist's Statement (GC-14423) and attach to this claim form. Be sure to identify the related tooth number for all dental procedures and include extraction dates or original placement date and reason for replacement of denture or bridge replacement.
  - If the claim is for a bridge or denture, we will need a chart of all other missing teeth in the mouth, and their dates of extraction.
- **For periodontal services** (gum disease), member must submit x-rays and periodontal charting.
- **For orthodontic services, the following information must be provided: date appliance placed, number of months of treatment, months of treatment remaining.**
- **For services related to an accidental injury**, the patient must always include pre-treatment x-rays and details of the accident.

| 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)*  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please Retain A Copy For Your Records**

