# Claim Form for Dental Treatment Reimbursements

For the quickest way of submitting your claim, log into Health Hub at www.aetnainternational.com and submit your claim online.

## How to complete this form

One form must be completed for each claimant, for each dental condition treated. Please complete clearly in BLOCK CAPITALS.

Sections 1 to 7 must be completed in full by the claimant or the main member/spouse on their behalf, if the claimant is a dependant under the age of 18.

Section 8 must be completed by the dental practitioner, if required.

Assessment of the claim may be delayed if all the necessary sections of this form are not completed.

We may need to contact the claimant's dental practitioner, for more dental information in order for us to process the claim under the terms and conditions of the policy. We will tell you if we need to do this.

**For information on how to contact us please refer to the 'Where to send your claim' section on page 6.**

### Section 1: Claimant details (for whom the claim is for)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other: _____

Family name (surname): _____ First name(s): _____

Date of birth (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Member ID[1]: _____ Plan number: _____

Plan sponsor: _____

### Section 2: Main member/spouse details (if completing the form on behalf of the claimant)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other: _____

Family name (surname): _____ First name(s): _____

Date of birth (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Member ID[1]: _____ Plan number: _____

Plan sponsor (if applicable): _____

[1] as shown on your Member ID Card.

### Section 3: Contact details for this claim

Correspondence address: _____

Town: _____ Postcode: _____ Country: _____

Email

Daytime phone: _____ Evening phone: _____

If you are sending this claim to us through your Broker or Plan Sponsor, and you wish for your claims statement (EOB) to be sent directly to them, please tick the box applicable to you. Broker ☐ Plan Sponsor ☐

### Section 4: Claim summary

Is this a new claim? If 'Yes', complete the following and refer to 'How to complete this form' for further advice.

What symptoms did the claimant have which needed treatment? _____

_____

_____

Confirm the dental condition or diagnosis if known: _____

### Section 5: Declaration – the Declaration must be signed by the claimant or the main member/spouse if the claimant is a dependant under the age of 18

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 dental information in relation to this claim, or any other claim related to the member/covered individual, from any third party, including providers and dental practitioners. I declare and agree that personal information may be collected, held, disclosed, or transferred (worldwide) to any organisation within the Aetna group, its suppliers, providers and any affiliates.

| Claimant/main member's/spouse's name & signature: | Date (dd/mm/yyyy) |
|---|---|
| | |

Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.

**Section 6: Claim details**

Is this a new claim? ☐ Yes ☐ No If 'Yes', complete the following and refer to 'How to complete this form' for further advice.

Detail the symptoms/dental condition that the claimant received treatment for: _____

Is this claim for a dental checkup? ☐ Yes ☐ No If 'Yes', Section 8 does not need to be completed.

Provide the breakdown of the invoices being submitted with this claim:

| **Country of treatment** | **Date of treatment** (dd/mm/yyyy) | **Invoice date** (dd/mm/yyyy) | **Invoice reference** | **Invoice amount** (including currency) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Use a separate sheet if you need more space.** | | | | Total number of invoices: |

Does the claimant have another insurance plan or policy that covers dental costs? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name of the insurer, the insurer's address and the claimants plan or policy number with that insurer: _____

Is the claim as a result of an accident? ☐ Yes ☐ No

If 'Yes', provide the circumstances of the accident including how it happened, the location, the time and the date, using a separate sheet if you need more space: _____

If the claimant has suffered an injury as the result of an accident, are they claiming from a third party? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name and the plan number below:

## Section 7: Payment details

**Who are we reimbursing?**

| ☐ Claimant/Main member | ☐ The provider | ☐ Another person or entity |
|---|---|---|
| *Please complete the rest of this section below to tell us how you would like to be paid.* | *We can only pay them if their bank details are shown on the invoice. You don't need to fill in the rest of this section.* | *If they paid on your behalf:*<br>Name: _____<br>Relationship you: _____<br>If they didn't pay on your behalf but you'd like us to pay them, please tell us the reason why you want us to pay them instead of you, and fill in payee details below. |

**How would you like to be paid?**

☐ Using your current Recurring Reimbursement Election (RRE) information

*No further information required*

☐ 1. By bank transfer

Account holder name: _____

If the account holder name is different to the names given in Section 1 and 2, tell us their full address and Email. We will not be able to make the payment without this information:

Account holder address: _____

_____

_____

_____

Email

Bank name and address (including town/city and country): _____

_____

_____

_____

Postcode: _____ BIC/Swift code (must be completed): _____

Payment Currency: _____ Bank account currency: _____

Account number: _____ IBAN: _____

Sort code (for UK accounts): _____ Routing code: _____

ABA number (for transfers to U.S located banks): _____

☐ Mark here to use these details as your RRE

☐ 2. By foreign draft or cheque

Account holder name: _____

If the account holder name is different to the names given in Section 1 and 2, tell us their full address and Email. We will not be able to make the payment without this information:

Account holder address: _____

_____

_____

Email

Payment Currency: _____

Please note that banks may not always accept foreign drafts in all currencies.

## Section 8: Dental treatment – must be completed by the dental practitioner

**1. Contact and registration details**

Name of dental practitioner: _____

Qualifications: _____

Tax Identification Number (required for providers practising in the US): _____

Phone: _____ Fax: _____

Address: _____

Town: _____ Postcode: _____ Country: _____

Email: _____

Date the patient first registered with you/the clinic/the hospital (dd/mm/yyyy): _____

**2. Symptoms**

a) Provide full details of the symptoms presented to you: _____

_____

b) Provide full details of the clinical findings on examination and note them on the chart below:

| Dental chart | **Permanent teeth** | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Treatment | | | | | | | | | | | | | | | | | |
| Finding | | | | | | | | | | | | | | | | | |
| Upper jaw | 18 | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | Upper jaw |
| Lower jaw | 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | Lower jaw |
| Finding | | | | | | | | | | | | | | | | | |
| Treatment | | | | | | | | | | | | | | | | | |

| Dental chart | **Deciduous teeth** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Treatment | | | | | | | | | | | |
| Finding | | | | | | | | | | | |
| Upper jaw | 55 | 54 | 53 | 52 | 51 | 61 | 62 | 63 | 64 | 65 | Upper jaw |
| Lower jaw | 45 | 44 | 43 | 42 | 41 | 71 | 72 | 73 | 74 | 75 | Lower jaw |
| Finding | | | | | | | | | | | |
| Treatment | | | | | | | | | | | |

**Finding:**

| | | | |
|---|---|---|---|
| b = | bridge | gs = | gingival swelling |
| c = | crown | i = | implant |
| ca/da/dn = | caries/decay/ dental necrosis | in = | inlay |
| | | m = | missing tooth |
| cl = | calculus | p = | periodontis |
| g = | gap closure | pu/od = | pulpitis or odontitis |
| gb = | gingival bleeding | | |
| gi = | gingivitis | | |

**Treatment:**

| | | | | | |
|---|---|---|---|---|---|
| AF = | amalgam filling | M = | metal ceramic crown | PR = | panoramic radiograph |
| CF = | composite filling | NB = | new bridge | RB = | replacement bridge |
| | | NC = | new crown | RC = | replacement crown |
| D = | denture | O = | orthodontics | RCT = | root canal treatment |
| E = | extraction | ON = | onlay | S&P = | scale and polish |
| I = | implant | OR = | oral radiograph | | |
| IN = | inlay | | | | |

c) Are the symptoms related to a previously diagnosed dental/gum/orthodontic condition? ☐ Yes ☐ No

If 'Yes', specify the dental/gum/orthodontic condition: _____

d) On what date did the patient first notice symptoms of the dental condition (dd/mm/yyyy)? _____

e) On what date did the patient first present these symptoms to you (dd/mm/yyyy)? _____

**3. Diagnosis**

_____

_____

_____

*(continued)*

## Section 8: Dental treatment – must be completed by the dental practitioner *(continued)*

**4. Breakdown of costs**

| **Invoice reference** | **Treatment** (include the number of surfaces if any restoration was done and the number of canals if any RCT was done) | **Invoice amount** (including currency) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**5. Declaration**

I declare that to the best of my knowledge and belief the information given in this section of the Claim form is full, true and complete.

Dental practitioner's signature: _____

Date (dd/mm/yyyy): _____ Practice stamp:

## Section 9: Further information

**How to complete this form**

- If you are personally seeking reimbursement, we will only issue payment to:
  - the claimant if they are 18 or over
  - the plan holder if the claimant is under 18 and is a dependant under the plan, or
  - the parent or legal guardian named as the primary member, if the claimant is under 18
- Ensure that you are able to receive payment in the method and currency you have requested.
- We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or recipient bank service charges. Please contact your bank for further details.
- If you do not give us the sort code/routing code, BIC/ SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.
- Payment by foreign draft or cheque in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft or cheque. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the base currency of your plan.
- Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.
- Whenever coverage provided by any insurance policy is in violation of any US, UN or EU economic or trade sanctions, such coverage shall be null and void. For example, 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 Assets Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions
- We will process the claim if the invoices and receipts for the treatment costs incurred contain all of the following:
  - diagnosis of the dental condition treated
  - treatment date
  - type of treatment, including the tooth number, number of surfaces if restoration work was done and/or number of canals if Root Canal Treatment was done, and
  - the dental provider's official stamp

**What to send us**

Send us the claim within 180 days of the first treatment date. You must send the following items to make sure that we can process your claim:

- the fully completed Claim form
- the original itemised invoice
- the original receipt. We do not accept credit card statements as proof of payment
- a copy of the prescription if you are claiming for medication
- a copy of the investigative tests results if relevant (e.g. x-rays, scans)

**Where to send your claim**

Send us your claim in one of the ways listed below:

- By logging in to your Health Hub at www.aetnainternational.com and submitting your claim online.
- By email to: AsiaPacServices@aetna.com.
- By post to: : Aetna Global Benefits Limited (Singapore Branch), 112 Robinson Road, #09-01 Robinson 112, Singapore, 068902, Singapore

We know you may have questions and we're always here to help. You can call us any time on:
Phone: 1-800-723-1241 (Free from Hong Kong)
+65-6701-6912 (Collect or Direct)



Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.