



Claim Form

Medical Dental Vision

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 8.5 x 11 paper.

Aetna Global Benefits
P.O. Box 30258
Tampa, FL 33630-3258
USA

OR Aetna Global Benefits
4630 Woodlands Corporate Blvd.
Tampa, FL 33614
USA

Telephone: (800) 231-7729 (outside the USA, via AT&T + access)
(813) 775-0190 (direct or collect outside the USA)

Facsimile: (800) 475-8751 (outside the USA, via AT&T + access)
(813) 775-0625 (inside the USA)

E-mail: <https://agbservice@aetna.com>

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

City _____

State/Province _____ Country _____

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

If the patient is over the age of 19 and attending school, you must provide verification, such as report cards, tuition statements, etc., once per school year.

3. Summary of Medical, 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 dentures and bridges: the date or dates of extraction of teeth involved. If it is a denture or bridge replacement, include the date of prior placement **and reason for 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) Name and Address (If the Provider's name and address is on receipts, write "see receipts")	Description of Service (If hospital, indicate inpatient or outpatient)	Diagnosis (Reason for visit)	City/State/ Providence/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

