Aetna International Claim Form
Aetna International 理赔申请表

华泰保险 Huatai Insurance
华泰财产保险有限公司

Please submit this 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. Failure to complete all sections of this form may result in claim processing delays.
请填写本理赔申请表并与明细账单和收据一同提交。每一名家庭成员需要单独一份理赔申请表。请将较小收据贴在一整张纸上。本申请表要求填写的各个部分如有遗漏，可能延误理赔的办理。

Please refer to your policy documents to verify the cover available through your Plan.
请参阅您的保单文件，确认您保险计划中涉及的保险责任范围。

If the claim amount is above RMB 10,000, or in case the claim amount is in non-RMB currencies, for any claim amount above USD 1,000 or equivalent, please attach your valid ID card/passport copy.
如果索赔金额高于人民币 1 万元以上或者外币等值 1000 美元以上的，请附上您的有效身份证/护照复印件。

Please note Aetna International is not responsible for any costs associated with the completion of this form or for any further information/document requested by Us to assess Your claim. The issuing of this Claim Form is in no way an admission of liability.
Aetna International将不承担与本申请表填写或者我们为评估您索赔所要求的任何其他信息/文件所产生的任何相关费用。提供本理赔申请表不代表我们以任何方式承认任何责任。

1. Patient Information – Must be completed **患者信息**（必须填写）

Policyholder Name 投保人名称 _____ Policy Number 保单编号 _____

Patient's Full Name 患者全名 _____

Patient's Date of Birth 患者出生日期 _____ Patient's Aetna Identification Number 会员编号 _____

Gender 性别 Male ☐ 男 Female ☐ 女 Relationship 与主被保险人关系 Self ☐ 本人 Spouse ☐ 配偶 Child ☐ 子女 Other ☐ 其他 _____

- If the claim amount is above RMB 10,000, or in case the claim amount is in non-RMB currencies, for any claim amount above USD 1,000 or equivalent, please complete the following.
- 如果索赔金额高于 1 万元以上或者外币等值 1000 美元以上的，请务必完成以下部分。

Type of ID 证件类型 _____ ID Expiration Date (dd/mm/yyyy) 证件有效期（日/月/年） _____

ID Number 证件号码 _____

Nationality 国籍 _____ Occupation 职业 _____

2. Contact Information – Must be completed **联系方式**（必须填写）

Contact Name 联系人姓名 _____ E-Mail Address 电子邮件地址 _____

Postal Address (please include ZIP code) 邮寄地址 (需含邮政编码) _____

Telephone Number 联系电话 _____ Mobile Number 手机号码 _____

Pending or denied claim notifications will be delivered by e-mail, paid claim notifications will be delivered by post.
未决或拒绝理赔通知书将通过电子邮件发出，赔付理赔通知书将通过平邮寄出。

3. Other Health Insurance Coverage – Must be completed **其他医疗保险范围**（必须填写）

Do you hold any other health insurance? 你是否同时持有了其他健康保险？ No ☐否 Yes ☐是

Other Carrier Name 其他保险运营商名称 _____

Other Insurance Policy Number 其他保险单编号 _____ Policy Holder Name 投保人姓名 _____

Please submit the relevant documents for the details if you get the reimbursement from other insurance for this claim submission.
如果针对本次索赔申请您已经从其他保险商获得赔偿，请提交关于详细信息的有关文件。

Please read carefully the disclaimers at the end of this form.

Please Retain a Copy for Your Records

4. Claim Information (Please include diagnosis or reason for treatment for each service received)
索赔信息（请为接受的每一项医疗服务填写诊断或者治疗原因）

- If the treatment is received within China, include detailed medical records and original Chinese invoices (Fapiao).
  如果在中国境内接受治疗，应附上详细医疗记录和发票原件。
- For services related to an accidental injury, details of the accident must be provided.
  与意外伤害有关的医疗服务，须提供关于该次意外事件的详细信息。
- For conditions that have required long term treatments, please provide details of when the symptoms and/or treatment began.
  对于已经接受长期治疗的疾病，请提供症状和（或）治疗开始情况的详细信息。
- Claims for prescribed drugs or medication should include a prescription from your general practitioner (GP) or medical specialist.
  对于处方药物或药物治疗的索赔，请提供您的全科医生或者医疗专家开具的处方。
- Acupuncture, Podiatry, Chiropractic, Osteopath, Homeopath treatment and physiotherapy require a referral from your GP or medical specialist.
  针灸、足疗、整脊、整骨、顺势治疗和理疗需要您的全科医生或者医疗专家开具转诊信。
- If you have insufficient space in any section, please provide full details on separate sheet.
  如果表格留空不足，请另页填写详细信息。

Dates of Services 医疗服务日期	**Provider's (physician, clinic, hospital, pharmacy, dentist) Name and Address (If the provider's name and address is on receipts, write "see receipts")** 服务提供者（医生、诊所、医院、药店、牙医）的名称/姓名和地址（如果收据上有服务提供者的名称/姓名和地址，请填写"见收据"）	**Description of Service/ Name of Medication/ Device (If hospital, state Inpatient, Day Case or Outpatient)** 服务明细/药品/设备名称（如果在医院治疗，请说明是住院治疗、日间留院或者门诊治疗）	**Diagnosis (Reason for visit)** 诊断（就诊原因）	**Country of Claim** 费用发生国家	**Currency of Claim** 发生费用的货币	**Total Charge** 收费总额

5. Summary of Payment Details – Must be completed **付款信息概述**（必须填写）

Recurring Reimbursement Election 付款信息使用方式：

☐ Receive future payments using the details provided below 通过以下具体信息收取未来付款
☐ Use the payment information provided below for this claim only 仅为本次索赔使用以下具体付款信息
☐ Use the payment details that we already have on file for you 使用我们已经为您备案的付款信息

Payment Information for Bank Transfer 银行转账信息

Please indicate your preferred payment currency (If none is indicated, the default currency is RMB.)
请说明您首选的付款货币（如果没有具体说明，默认货币将为人民币） _____

(If receiving Treatment inside mainland China, the currency of claim must be RMB.)
（如果在中国大陆境内接受治疗，索赔货币必须是人民币。）

Payee Name
收款人名称/姓名 _____

Specify if: Member Provider
具体说明： ☐ 会员 ☐ 服务提供者

Bank Account Holder Name (as per Bank Statement)
银行账户持有人姓名（以银行对账单为准） _____

Bank Account Number
银行账号 _____

Bank Name & Branch Name
银行名称 (含支行名称) _____

IBAN Code*
IBAN 编码* _____

Swift/BIC Code
Swift/BIC 编码 _____

IFSC/ABA/ US Routing Code
IFSC/ABA/ US 银行代码 _____

Sort Code/Branch Code
银行区号/分行号码 _____

Bank Address (include Country)
银行地址（包括国家） _____

Bank Telephone Number (include Country Code)
银行电话号码（包括国家编码） _____

*The IBAN is mandatory for bank transfer claim payment transactions in certain countries, such as the United Arab Emirates (UAE).This must be supplied if you are using a bank account in one of these countries. Members should check with their bank to confirm any IBAN requirements.
*在某些国家，例如阿拉伯联合酋长国（阿联酋），要求使用 IBAN 码对索赔支付交易进行银行转账。如果您在上述国家之一使用银行账户，必须提供 IBAN。会员应向其银行咨询并确认所有 IBAN 要求。

Please read carefully the disclaimers at the end of this form.

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6. Declaration – Must be completed **声明**（必须填写）

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.

我声明，仅就本人所知，本索赔提供的所有信息均真实准确。我了解 Aetna 将使用上述提供的信息。我同意并接受，依据本声明，Aetna 及其代表将有权要求获得关于本次索赔或者任何与成员/担保个人有关，并取自于任何第三方（其中包括服务提供商和医生）的过去、当前和未来的医疗信息。我声明并同意，个人信息可以在 Aetna 集团内部的任何组织机构及其供应商、服务提供商和任何关联方内部收集、持有、公开或转让（世界范围内）。

Patient's Signature **Date**

患者签名 _____ **日期** _____

(If patient is under 18 years of age, Parent or Guardian must sign.)（如果患者不足 18 周岁，须由患者父母一方或监护人签字）

7. Medical Information 医疗信息 (To be completed by Provider 由医疗服务提供者填写)

1. Details of Medical Condition or Diagnosis
   疾病症状或诊断 _____
2. Underlying Cause
   主要病因 _____
3. When did the symptoms first arise (dd / mm / yyyy)
   症状初次发现时间 （日/月/年） _____
4. Is further treatment required? Yes No
   是否需要继续治疗？ ☐ 是 ☐ 否
   If Yes, please provide treatment plan
   如果需要，请提供诊疗计划 _____
5. Other supplementary information
   其他补充信息 _____
6. If this visit included diagnostic procedures, other treatments or medicines, please provide results, reports or prescriptions
   如果就诊内容包括检查、治疗或者配药，请提供相应的诊断结果、报告或者处方

医生姓名 Name of Practitioner	公章 Official Stamp
地址 Address	
电话 Telephone	
电邮 E-mail	传真 Fax
医生签名 Practitioner's Signature	日期(日/月/年) Date(dd/mm/yyyy)

8. How to submit a Claim 如何提交理赔申请

- **Postal Submission 邮递**

  Aetna (Shanghai) Enterprise Services Co., Ltd.
  Suite 1302
  Harbour Ring Plaza, 18 Middle Xi Zang Rd.
  HuangPu District, Shanghai, China, 200001
  安态（上海）企业服务有限公司
  地址：中国上海黄浦区西藏中路港陆广场 18 号 1302 室
  邮编：200001

  For claim related queries please contact our Member Services helpline
  理赔相关咨询请联系我们的会员服务热线
  +86 400 881 1291

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