Aetna International Claim Form

Aetna International 理赔申请表

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, USD 1,000 or equivalent, please attach the valid ID card / passport copy of the beneficiary.
如果索赔金额高于1万元人民币或者外币等值1千美元，请附上受益人的有效的身份证/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 1 千美元以上的，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 ____________________

Residence or Office Address (please include ZIP code) 住所地或工作单位地址 (需含邮政编码) ____________________

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

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。

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。

请仔细阅读表格最后列示的免责申明 **Please read carefully the disclaimers at the end of the forms.**

请保留副本以作记录 **Please Retain a Copy for Your Records**

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 treatment was received in mainland China, RMB policy can only be reimbursed in RMB and USD policy can only be reimbursed in USD.)
请说明您首选的付款货币（如果在中国大陆境内接受治疗，人民币保单只能赔付人民币，而美金保单只能赔付美金。）___________
(If none is indicated, the default currency of RMB policy is RMB and the default currency of USD policy is USD.)
（如果没有具体说明，人民币保单默认货币将为人民币，而美金保单默认货币将为美金。）

Payee Name
收款人名称/姓名 ________________________________
Specify if: 具体说明： Member ☐会员 Provider ☐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。

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

I declare that all information, to the best of my knowledge, provided on this Claim Form is truthful and correct. I also understand that this declaration gives permission to my insurance company and their appointed representatives to approach any third party for information required to complete their assessment of this claim including, but not limited to, my current and previous Medical Practitioners.
上述各项内容，及本人提供的一切资料，均完全属实。本人授权贵公司或其指定代表向任何第三方获取处理索赔的信息，提供有关本人此次意外或疾病的一切资料及本人既往的健康状况、病历和诊疗资料。
I declare and agree that the personal information collected or held by my insurance company, whether contained in this form or otherwise obtained may be used by my insurance company, or disclosed or transferred to any organization for the purpose to (1) assess this claim and to provide on-going insurance and customer services, (2) process and give effect to Credit Card Payment,(3) provide marketing material in respect of insurance related services of my insurance company or its associated companies and (4) process claims or analyze the insurance.
本人允许贵公司在以下情况下使用、透露本人的个人信息（包括在本表中填写的信息和其它途径收集到的信息）①评估本次索赔或进行客户服务②因付款需要通知银行或信用卡公司③为贵公司或相关机构作与保险相关服务市场资料④处理索赔或保险研究使用。
If the chosen settlement currency is not RMB, I authorize my insurance company to purchase foreign exchange for claim reimbursement up to the policy benefit maximum.

请仔细阅读表格最后列示的免责申明 **Please read carefully the disclaimers at the end of the forms.**

请保留副本以作记录 **Please Retain a Copy for Your Records**

如保险金货币选择‘非人民币’，本人委托贵公司办理以所给付的保险金金额为限的购汇业务。
For Direct Billing case or guaranteed case which the medical treatment received in the pre-appointed provider, I hereby authorize the provider or pre-appointed third party to directly bill my insurance company which should make payment of any benefit payable to the provider or pre-appointed third party.
对于发生在事先约定的医疗机构内，针对特定的或保险公司已经事先担保的医疗服务项目，我授权该医疗机构或指定的第三方代表我向保险公司提出理赔，保险公司将直接付款至该医疗机构或指定的第三方。

Patient's Signature 患者签名 ______________________ **Date 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? 是否需要继续治疗？ Yes ☐ 是 No ☐ 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

Policies are issued by the insurance company stated in your policy documents and administered by Aetna (Shanghai) Enterprise Services Co., Ltd., a fully-owned subsidiary of Aetna Inc. Aetna (Shanghai) Enterprise Services Co., Ltd. is part of Aetna Inc.'s international department, Aetna International. Aetna® is a trademark of Aetna Inc. and is protected throughout the world by trademark registrations and treaties.
保单由您的保单文件中载明的保险公司签发并由安态(上海)企业服务有限公司提供管理服务。安态(上海)企业服务有限公司是 Aetna Inc. 的全资控股子公司。安态(上海)企业服务有限公司隶属于 Aetna Inc. 国际业务部 Aetna International. Aetna®是 Aetna Inc. 的注册商标并在全球范围内受商标注册条约的保护。

请保留副本以作记录 **Please Retain a Copy for Your Records**