Aetna Singapore Health Insurance
Claim Form

If you have any questions about how to submit your claim, get in touch with us at **aetna@ihp.com.sg** or **6715 6446.**

A. General claim submission instructions

- Complete and answer all questions in full. Please indicate 'N.A.' if the question is not applicable.
- Submit this original completed form and all claim documents (as mentioned in part B, C and D, as applicable) as soon as possible after your treatment (and in any event no later than six months) to:

  Email: aetna@ihp.com.sg
  Post: Claims Department, Integrated Health Plans, 10 Chang Charn Road #04-00, Singapore 159639
- If you're submitting electronic copies of supporting invoices and receipts, please keep the original copies for 6 months from your claim submission date. We may ask you to send these documents to us as we assess your claim. In the event original bills and receipts are not available during our assessment, we may not be able to pay your claim.
- If you're submitting your claim by post, please keep copies of the information about your claim for your own records. We won't be able to return any original claim documents to you after we've assessed the claim.
- If your claim is approved, payment will be made to your nominated bank account as indicated on this form.

B. For outpatient, dental, maternity, and preventative care claims

- Complete part 1 and relevant portions of part 2 of this claim form.
- You'll need to submit all relevant invoices and receipts, as well as referral letters where required (refer to your benefit schedule).

C. Upon admission to hospital (inpatient claim)

If you're a Singapore citizen or permanent resident and are admitted to hospital, you/your personal representative must sign the Medisave authorisation form if your expenses can be paid out of a Medisave account. You'll also have to pay any deposit required by the hospital.

D. Upon discharge

- Complete parts 1 and 2 of this claim form.
- If you're being discharged from a private hospital, have your attending medical professional complete part 3 of this claim form.
- Include the following documents in your submission:
  - final summary and itemised hospital bills
  - doctor's bills and receipts
  - invoices or receipts for pre-admission and post-hospitalisation treatment (claims for pre-admission specialist consultations will require a referral letter from a medical practitioner)
  - If you're being discharged from a Singapore Government Restructured Hospital, also include your discharge summary (provided free of charge to you at discharge), copy of ambulatory form, pre-admission form, blood tests and histology reports from the hospital.
  - if you've made a claim against a Medisave-approved Integrated Shield Plan, include a copy of the claim settlement advice
  - any other documents to support your claim

Part 1: To be completed by the main member	
Name of employer:	
Name of main member:	
NRIC/FIN no.:	Member ID:
Date of birth: DD MM YYYY	Contact no.:

Email address:		
Claim payment details (bank transfer)		
Bank Name	Branch Code (3 digits)	Bank A/C No.

Part 2: To be completed by the claimant

Name of claimant (if not the main member):	
NRIC/FIN no.:	Date of birth: DD MM YYYY
Relationship to main member:	

If your claim is for Outpatient or Dental treatment, please complete the following details.

Date of Visit: DD MM YYYY	Diagnosis:	Accident related? If yes, provide details of accident:	Incurred Amount:
Date of Visit: DD MM YYYY	Diagnosis:	Accident related? If yes, provide details of accident:	Incurred Amount:
Date of Visit: DD MM YYYY	Diagnosis:	Accident related? If yes, provide details of accident:	Incurred Amount:

If you are making a claim for treatment by a specialist and/or physiotherapist, please answer the following questions:

Is this claim related to your first visit to a specialist for the diagnosis above? (If yes, please attach a copy of your referral letter.)	Is this claim for follow-up treatment from inpatient/daycare treatment? If yes, please state the date of inpatient/daycare treatment: DD MM YYYY

Is this a work-related injury? ☐ Yes ☐ No

If your claim is for Inpatient/Daycare treatment, please complete the following details.

Date of admission: DD MM YYYY	Date of discharge: DD MM YYYY	Name of hospital / clinic:

If inpatient treatment is due to illness:

Diagnosis:	Symptoms experienced:

Has the illness been treated before?	Date symptoms first started: DD MM YYYY	Date first treated: DD MM YYYY

Details of treatment:

If treatment is due to an accident:

Date of accident: DD MM YYYY	Time of accident:	Place of accident:

Briefly describe the accident and the extent of the injury:

Is this a work-related injury? ☐ Yes ☐ No	
If you're making a claim for Maternity benefits, please complete the following details.	
What is the estimated date of delivery? DD MM YYYY	Is the pregnancy the result of assisted conception treatment(s)? ☐ Yes ☐ No
If you're making a claim for Preventative Care benefits, please complete the following details.	
Date of visit: DD MM YYYY	
Are you making a claim from other insurance companies?	
If yes, state the name of the other insurance company: (please submit a copy of the other insurance company's claim settlement letter/payment voucher)	Policy no.:

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 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 organisation within the Aetna group, its suppliers, providers and any affiliates.

I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to give the company or the authorised representative, any and all information about sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital and medical records. This information is required by Aetna Global Benefits (UK) Limited (Singapore Branch) in order to confirm coverage for my medical condition and proposed treatment.

_____ _____

Signature of Claimant Date (DD MM YYYY)

Part 3: Medical report to be completed by the medical professional where possible

Name of Company:	Name of Patient:
NRIC/ FIN No:	Date of Birth: DD MM YYYY
Date of Admission: DD MM YYYY	Date of Discharge: DD MM YYYY
Name of Hospital:	
Date of first consultation: DD MM YYYY	Final diagnosis (based on ICD 10):
ICD Code 10:	Date of diagnosis: DD MM YYYY
What is the cause of illness/injury?	What is the anatomy of this illness?

Type of Operation(s) / surgical procedure(s) performed: i. Date Performed DD MM YYYY ii. Type of Operation(s) / Surgical Procedures iii. Operation Codes* iv. Operation Tables* *for surgery done in Singapore, based on the Tables of Surgical Procedures (TOSP) issued by the Ministry of Health Singapore	Please indicate treatment rendered if no surgery was done.
Please advise period of medical leave given.	Is this a job-related injury? ☐ Yes ☐ No
Has the patient had any prior treatment for this condition? ☐ Yes ☐ No If 'Yes', please state the date of treatment, name and address of the previous doctor who treated the patient.	Was the patient referred by another doctor? ☐ Yes ☐ No If 'Yes', please provide the name and address of the referring doctor.

Is the condition/treatment related to:

i. Pregnancy or childbirth ☐ Yes ☐ No

ii. Infertility or sub-fertility condition ☐ Yes ☐ No

iii. Congenital anomaly ☐ Yes ☐ No

iv. Genetic or chromosomal disorder ☐ Yes ☐ No

v. Mental, nervous, emotional or psychiatric disorder ☐ Yes ☐ No

vi. Cosmetic Surgery ☐ Yes ☐ No

vii. Is the surgery for correction of short sightedness? ☐ Yes ☐ No

viii. Abortion / Miscarriage / Impotency / Sterilisation ☐ Yes ☐ No
(If related to a miscarriage, was it due to accident? ☐ Yes ☐ No)

ix. Sexually transmitted disease / AIDS / Illness or disease related to HIV ☐ Yes ☐ No

x. Self-inflicted injury / Drug Addition / Alcoholism ☐ Yes ☐ No

xi. Sleep apnoea / Obesity / Weight reduction or improvement ☐ Yes ☐ No

xii. Dental / Gum treatment or oral mucosal ☐ Yes ☐ No (If "Yes", please elaborate.)

Was the above condition discovered during your investigation of his/her fertility condition? ☐ Yes ☐ No	Please specify the approximate date of discovery of the illness or injury. DD MM YYYY
Did the patient have any symptoms prior to consulting you? ☐ Yes ☐ No If "Yes", please indicate the nature of symptoms and date the symptoms first started.	How long has the illness/injury existed prior to consulting you?

If an excision was performed, please indicate the size of the lesion/tumour (please attach a copy of the histology report).	Name of (a) Physician, (b) Surgeon, and (c) Anaesthetist involved in the surgery
If there are no symptoms, what prompted the patient to see you?	Doctor previously consulted by the patient for the above condition. i. Name of doctor ii. First consultation iii. Name of clinic iv. Address
Is the patient still under your care for this condition? ☐ Yes ☐ No If 'Yes', please state the estimated duration the patient will need follow-up treatment with you. If 'No', please provide the date service was terminated with you. If you have referred the patient to another doctor, please provide their name and address.	If this condition existed before symptoms became apparent to the patient, please indicate when (in your view) this condition began to develop.

_____ _____

Signature of physician Date (DD MM YYYY)

_____ _____

Name / Designation Name and address of clinic/hospital & stamp