



Claim Form for Medical Treatment Reimbursements

Please complete clearly in BLOCK CAPITALS.

One form must be completed for each patient, for each medical condition treated.

The sections marked by an asterisk (*) must be completed in full by the patient, or the main member on behalf of the patient if the patient is a dependant under the age of 18. Assessment of the claim may be delayed if all the necessary sections of this form are not completed.

Further information about how to complete this form can be found on the last two pages.

* Section 1: Main member/claimant details

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:					
Correspondence address:					
Town:	Postcode:	Country:			
Email:					
Daytime phone:		Evening phone:			

¹ as shown on your Member ID Card - it could be 6 or 8 digits.

* Section 2: Patient details (if different from Section 1)

Title: 🗌 Mr 🗌 Mrs 🗌 Miss 🔲 Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Gender: 🔲 Male 🔲 Female
Member ID ¹ :	

* Section 3: Claim details

Section 5. Claim details						
Is this claim for a general wellness	checkup?	ſes	🗌 No	lf 'Y	es', Section 6 does not	need to be completed.
Is this claim for optical care?		ſes	🗌 No	If 'Yes', Section 6 does not need to be completed. the instructions on the last two pages of this form for documents you need to submit.		wo pages of this form for the
Is this claim for a repeat prescription for an existing medical condition we have reimbursed you before?		íes (🗌 No	If 'Yes', Section 6 does not need to be completed and must provide the relevant claim number:		
Is this a new claim?			🗌 No	If 'Yes', complete the following and refer to 'How to: complete this form' for further advice.		
What symptoms did the patient hav	e which needed tre	eatmo	ent?			
Confirm the medical condition or dia	agnosis if known: _					
Is this a claim for hospital cash ben	efit?	ſes	🗌 No			
If 'Yes', Section 6 must be completed discharge form from the hospital whe If 'No', provide the breakdown of the	re the treatment was	s pro	ovided together	with		d us the original admission and
Country of treatment	Date of treatmen		Invoice date		Invoice reference	Invoice amount
	(dd/mm/yyyy)		(dd/mm/yyyy)			(including currency)
Use a separate sheet if you need	more space.					Total number of invoices:
Does the patient have another insu	rance plan or policy	/ tha	t covers medic	al co	osts? 🗌 Yes 🗌 N	0
If 'Yes', provide the other insurer's details including the name of the insurer, the insurer's address and the patient's plan or policy number with that insurer:						
Is the claim as a result of an accide	nt? 🗌 Yes 🗌] No)			
If 'Yes', provide the circumstances sheet if you need more space:	of the accident inclu	uding	g how it happe	ned,	the location, the time an	d the date, using a separate
If the patient has suffered an injury	as the result of an	accio	dent. are they d	claim	ing from a third partv?	 □Yes □No
If 'Yes', provide the other insurer's			-			
		- 1141				

*Section 4: Declaration – the Declaration must be signed by the patient or the main member if the patient is a dependent 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 Archipelago Insurance Limited will rely on the information provided as such. I agree and accept that this declaration gives Archipelago Insurance Limited, 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.

Ρ	atient's/main member's signature:	Date (dd/mm/yyyy)

* Section 5: Payment details
Do you need us to pay the provider directly?
If 'Yes', we can only make payment to the provider if their bank details are included on the invoice.
Have you personally had to pay costs for the treatment that you are claiming for?
If 'Yes', and you are personally seeking reimbursement, you must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft or cheque', and completing the required information.
If another person or entity has paid on your behalf please give their name:
Please tick one of the following as applicable:
Use Recurring Reimbursement Election (RRE) information currently on file
Use the bank information provided in this section as your permanent RRE
Use the bank information provided below only for expenses related to this claim
 Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity: experiencing delays in receiving the claim settlement, and incurring additional bank charges
☐ 1. Bank transfer – this is the quickest and safest method of payment
Name of account holder:
If the patient's name (as given in Section 1) is different to the account holder name, please provide the following details:
Address of account holder:
Email address of account holder:
Telephone number of account holder:
Relationship to the claimant:
Bank account details:
Bank name:
Bank address (including town/city and country):
BIC/SWIFT code: Payment currency:
Currency of bank account:
Account number:
To help us direct your payments efficiently, supply the following as relevant:
IBAN (mandatory for all payments to bank accounts in countries that have adopted IBAN):
Sort code (mandatory for UK located banks):
Routing code/Branch code (as available):
ABA number (mandatory for transfers to US located banks):
□ 2. Foreign draft or cheque
Name to appear on the draft or cheque:
Currency of the draft or cheque:

Section 6:	Medical – must be com	pleted by the medical	practitioner/speciali	ist/therapist
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1. Contact and registration details
Name of medical practitioner/specialist/therapist:
Qualifications:
Tax Identification Number (required for providers practising in the US):
Phone: Fax:
Address:
Town: 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:
b) Has the patient suffered from the same or similar symptoms before?
If 'Yes', are the symptoms related to a previously diagnosed medical condition?
3. Diagnosis
-
Diagnosis of medical condition, if known: ICD10 code: Is there any underlying cause? Yes No
If 'Yes', provide details:
If 'Yes', was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident? Yes No
Treatment proposed:
Investigations requested, if any:
In your opinion, is this condition: Acute Chronic Chronic Acute episode of a chronic condition
4. Type of alternative treatment recommended, if relevant
Ayuverdic Podiatry Number of sessions needed:
5. Referrals
a) Was the patient referred to you?
If 'Yes', please complete the following:
Name of referring practitioner: Date of referral (dd/mm/yyyy):
Qualifications: Phone:
b) Have you referred the patient?
If 'Yes', provide the following details:
Name of specialist you referred the patient to:
Date of referral (dd/mm/yyyy): Phone:
Please provide a copy of the referral letters.
6. Hospital admission
Has the patient been admitted to hospital for this condition?
If 'Yes', provide the following details:
Admission date (dd/mm/yyyy): Discharge date (dd/mm/yyyy):
7. Declaration
I declare that to the best of my knowledge and belief the information I have given in the Medical section of this Claim form is full, true and complete.
Medical practitioner's/specialist's/therapist's signature:
Date (dd/mm/yyyy): Practice stamp:

How to complete this form

One form must be completed for each patient, for each medical condition treated.

Assessment of the claim may be delayed if the patient/main member and the patient's medical practitioner, specialist or therapist do not complete all the necessary sections of this form.

Sections 1 to 5 must be completed by the patient, or the main member on behalf of the patient if the patient is a dependant under the age of 18.

Section 6 must be completed by the patient's medical practitioner, specialist or therapist unless the claim is for:

- a repeat prescription for medication to treat a chronic medical condition and we have previously approved and paid claims for the same medication to treat the same chronic medical condition.
- optical care; in this instance you need to send us the optometric prescription and the itemised invoice for the prescription spectacle lenses, prescription spectacle frames and prescription contact lenses, or
- a general wellness checkup.

For any other type of claim, we understand that it may not always be possible to have Section 6 completed by the medical practitioner, specialist or therapist. In such circumstances, we will process the claim if the invoices and receipts for the treatment costs incurred contain all of the following:

- diagnosis of the medical condition treated
- treatment date
- type of treatment, and
- the medical provider's official stamp

We may need to contact the patient's medical practitioner, specialist or therapist for more medical 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.

A quick guide on how to submit your claim. For detailed information, please refer to the "Your guide to making a claim" section in your Claims Procedures.

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 where relevant (e.g. blood tests, x-rays, ultrasound, MRI / CT scan/ PET scan, audiometry, etc.)
- a copy of the physiotherapy or alternative treatment (chiropractic, osteopathic, homeopathic, etc.) referral by the medical practitioner or specialist if you are claiming for physiotherapy or alternative treatment costs, and
- copy of the admission and discharge reports where relevant for inpatient or daycare admissions.

Important information

Please remember these important points when completing your Claim form.

Section 3 – Claim details

If the patient has another insurance plan or policy that covers him/her for medical costs, we will need to know the details as it may affect the amount we pay in respect of their claim.

Section 4 – Declaration

If the declaration has not been read and signed, we will not be able to process the claim.

(Continued)

How to complete this form (continued)

Section 5 – Payment details

- If you are not personally seeking reimbursement we will pay the treatment provider directly, as long as the payment instructions are shown clearly on the invoice.
- If you are personally seeking reimbursement, we will only issue payment to:
 - the patient if they are 18 or over
 - the plan holder if the patient is under 18 and is a dependant under the plan, or
 - the parent or legal guardian named as the primary member, if the patient 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. For the current list of applicable currencies and countries please refer to our website.
- We cannot issue non-QAR foreign drafts or cheques to members/providers with bank accounts based in Qatar as the banks will not allow those to be encashed.
- 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 know you may have questions and we're always here to help. You can call us any time on the phone number listed on the back of your Member ID Card.

You can also send us a secure email by logging in to www.aetnainternational.com and clicking 'Contact us'.

You can scan your claims to us, rather than post them. It is important that any claim you send to us is done either by scan or originals, but not both.

Send your claim to us	
 By post: Archipelago Insurance Limited Unit 3A - 25 	 For the quickest and most convenient way of submitting your claim, please register for the secure member website at <u>www.aetnainternational.com</u> and submit your claim online.
Labuan Times Square U0350, Jalan Merdeka	 Send your claim via fax attaching receipts and all required documents from your medical practitioner, as explained above, to: +65-6395-6747
87007 F.T. Labuan Malaysia	 Send your claim via email with copies of your reciepts and all required documents from your medical practitioner, as explained above, to: <u>AsiaPacServices@aetna.com</u>
Contact us.	

• For claim related queries please contact our 24 hour Member Services helpline at:

Free from Malaysia 1-800-885-801 Collect or Direct +60-3-7724-4179

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If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

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Important: This is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.