EXECUTIVE HEALTHCARE SOLUTIONS

Claim Form for Dental Treatment Reimbursements

aetna™

Please complete clearly in BLOCK CAPITALS.

One form must be completed for each patient, for each dental 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

Family name (surname): _____

First name: _____

Middle name: _____

Date of birth (dd/mm/yyyy): _____

Gender ☐ Male ☐ Female

ID number (as shown on your Aetna card, it could be 6 or 8 digits): _____

Policy number (as shown on your Aetna card): _____

Group name (if applicable): _____

Correspondence address: _____

Town: _____

Country: _____

Postcode: _____

Email: _____

Daytime phone: _____

Evening phone: _____

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

Title ☐ Mr ☐ Mstr ☐ Mrs ☐ Miss ☐ Ms

Family name (surname): _____

First name: _____

Middle name: _____

ID number (as shown on your Aetna card, it could be 6 or 8 digits): _____

* Section 3 Claim details

Detail the symptoms/dental condition that the patient received treatment for:

Is this claim for a routine dental checkup? ☐ Yes ☐ No If 'Yes', Section 6 does not need to be completed.

Provide the breakdown of the invoices being submitted with this claim:

Country of treatment	Date of treatment	Invoice date	Invoice reference	Invoice amount (including currency)

Use a separate sheet if you need more space.

Total number of invoices:

Does the patient have another insurance plan or policy that covers dental costs? ☐ Yes ☐ No

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 accident? ☐ Yes ☐ No

If 'Yes', provide the circumstances of the accident including how it happened, the location, the time and the date, using a separate sheet if you need more space: _____

If the patient has suffered an injury as the result of an accident, are they claiming from a third party? ☐ Yes ☐ No

If 'Yes', provide the other insurer's details including the name and the plan number below:

* Section 4 Declaration – the Declaration must be signed by the patient or the main member if the patient 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 organization within the Aetna group, its suppliers, providers and any affiliates, including Executive Healthcare Solutions - Kenya, MIC Global Risks (Tanzania) Limited and EHS Limited.

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

* Section 5 Payment details

Do you need us to pay the provider directly? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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' / '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 claimant'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 number (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 / cheque

Name to appear on the draft / cheque: ____________________

Currency of the draft / cheque: ____________________

☐ **3.** Total Amount of Claim: ____________________

Section 6 Dental treatment – must be completed by the dental practitioner

1. Contact and registration details

Name of dental practitioner: _____

Qualifications: _____

Tax Identification Number (required for providers practising in the US): _____

Phone: _____ Fax: _____

Address: _____ Town: _____

Country: _____ Postcode: _____

Email: _____

Date the patient first registered with you/the clinic/the hospital (dd/mm/yyyy): _____

2. Symptoms

a) Provide full details of the symptoms that the patient presented to you: _____

b) Provide full details of the clinical findings on examination and note them on the chart below:

Dental chart	**Permanent teeth**																
Finding																	
Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw
Lower jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw
Finding																	

Dental chart	**Deciduous teeth**										
Finding											
Upper jaw	55	54	53	52	51	61	62	63	64	65	Upper jaw
Lower jaw	45	44	43	42	41	71	72	73	74	75	Lower jaw
Finding											

Finding:

b = bridge	g = gap closure	in = inlay
c = crown	gi = gingivitis	m = missing tooth
ca/da/dn = caries/decay/dental necrosis	gs = gingival swelling	p = periodontis
cl = calculus	i = implant	pu= pulpitis

c) Are the symptoms related to a previously diagnosed dental/gum/orthodontic condition? ☐ Yes ☐ No

If 'Yes', specify the dental/gum/orthodontic condition: _____

d) On what date did the patient first notice symptoms of the dental condition (dd/mm/yyyy)? _____

e) On what date did the patient first present these symptoms to you (dd/mm/yyyy)? _____

3. Diagnosis

_____

_____

_____

4. Treatment

Complete the dental chart by using the abbreviations below

Dental chart	**Permanent teeth**																
Finding																	
Upper jaw	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper jaw
Lower jaw	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower jaw
Finding																	

Dental chart	**Deciduous teeth**										
Finding											
Upper jaw	55	54	53	52	51	61	62	63	64	65	Upper jaw
Lower jaw	45	44	43	42	41	71	72	73	74	75	Lower jaw
Finding											

Treatment:

AF = amalgam filling	M = metal ceramic crown	PR = panoramic radiograph
CF = composite filling	NB = new bridge	RB = replacement bridge
D = denture	NC = new crown	RC = replacement crown
E = extraction	O = orthodontics	RCT = root canal treatment
I = implant	ON = onlay	S&P = scale and polish
IN = inlay	OR = oral radiograph	

(continued)

Section 6 Dental treatment – must be completed by the dental practitioner *(continued)*

5. Breakdown of costs

Invoice reference	Treatment (include the number of surfaces if any restoration was done and the number of canals if any RCT was done)	Invoice amount (including currency)

6. Declaration

I declare that to the best of my knowledge and belief the information given in this section of the Claim form is full, true and complete.

Dental practitioner's signature:	Date (dd/mm/yyyy):

Practice stamp

How to complete this form

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

Assessment of the claim may be delayed if the patient/main member and the patient's dental practitioner 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 dental practitioner unless the claim is for:

- a routine dental checkup.

For any other type of claim, we understand that it may not always be possible to have Section 6 completed by the dental practitioner. 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 dental condition treated;
- treatment date;
- type of treatment including the tooth number, number of surfaces if restoration work was done and /or number of canals if Root Canal Treatment was done; and
- the dental provider's official stamp.

We may need to contact the patient's dental practitioner for more 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 "Claims Procedure" section in your Member Handbook.

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; and
- a copy of the investigative tests results where relevant (e.g. x-rays, scans).

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.
- If the claim amount exceeds USD 16,500 per year **we** are required to carry identity checks of the claimant by collecting their valid photo identity document – passport / driving license / national identity card or any other photo identity document issued by the Government.
- 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 / 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 / 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.
- 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.

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 Aetna ID Card.

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

You can scan your claims to us and originals can follow later.

Send your claim to

- By post:

  Executive Healthcare Solutions
  6th Floor, 9 West
  Ring Road Parklands
  PO Box 14680, 00800, Westlands
  Nairobi, Kenya
  Tel: +254 20 291 0000
  Email: claims@executive-healthcare.com

  Aetna Global Benefits Limited
  PO Box 6380
  Dubai
  United Arab Emirates

- Send your claim via fax attaching receipts and all required documents from your medical practitioner, as explained above, to: +254 20 291 0600
- Send your claim via email with copies of your reciepts and all required documents from your medical practitioner, as explained above, to: claims@executive-healthcare.com
- For claim related queries please contact us on: +254 20 291 0000