CIEE Claim Form

Non-completion of this form may result in delay or denial. Please attach all available itemized medical bills, receipts and/or reports to this claim.

Medical/Prescription claims:

Aetna Student Health
PO Box 981106
El Paso. TX 79998

Non-Medical claims:

CIEE-Insurance Dept.
300 Fore St.
Portland, ME 04101

SECTION 1. PERSONAL INFORMATION-(Please Print)

1. **Full Name:**
2. **Insurance ID (located on your insurance ID card and confirmation of insurance form):**
3. **Date of Birth:**
4. **US Address:**
5. **Telephone Number:** **Email:**
6. **Do you have other insurance? If yes please provide name and policy number below:**

   Name of Insurance Company
   Policy Number

PLEASE SEND PAYMENT TO: Provider ◯ Me ◯ (Please attach proof of Payment) **Signature _____**

*****Aetna Student Health issues payment in check format and only to the insured or provider. Aetna Student Health does not send money via wire transfer and cannot issue payment to a third party, such as a friend or family member*****

SECTION 2. MEDICAL AND PRESCRIPTION REIMBURSEMENT

1. **Date of Accident or Illness_____**
2. **How did the condition begin? State fully all symptoms and describe the condition in detail from the beginning. For accidents, include how, when and where the accident occurred. For a prescription reimbursement, please state the medication that was bought, and what condition it is being used to treat.**

   _____

3. **When did the first symptom of this condition begin?_____**
4. **Have you ever had or been treated for this type of injury or illness before?_____**
5. **Name and Address of treating Physician, and dates you were treated by that Physician:**

Is this condition the result of an accident or illness:

Related to employment	**Yes** ◯	**No** ◯
Involving a motor vehicle	**Yes** ◯	**No** ◯
Was a police report filed?	**Yes** ◯	**No** ◯

If yes, please identify the Police department where it was filed.

If this accident or illness has resulted in an inpatient hospital admission, have you obtained pre-certification? _____
…….....
FAILURE TO COMPLY WITH NOTIFICATION REQUIREMENT WILL RESULT IN A PENALTY

SECTION 3. NON-MEDICAL REIMBURSEMENT
(Urgent Travel Expense, Loss of Luggage, Theft, Emergency Evacuation/Reunion, Repatriation)

1. **Date of Loss _____**
2. **Please describe what happened _____**

3. **Claims for theft or loss of luggage must have a list attached that includes the items being claimed, date of purchase, and value. The insurance policy requires that all non-medical losses must be reported to CIEE within 15 days of loss**

Please attach all original itemized bills, statements, reports and invoices for services and supplies and make sure your medical provider (if this is a claim for medical reimbursement) has included the following: Diagnosis Code; Procedure Code and the Provider's Tax ID Number. Please make certain that all documents indicate claimant's name, date of service and itemized charges. If you have any questions please call CIEE at 1-888-268-6245.

AUTHORIZATION FOR MEDICAL INFORMATION

To all Physicians, Hospitals, or other Health Professionals:

You are authorized to provide CIEE and Aetna Student Health and any independent consulting health professional or auditor acting on its behalf or that of the insurance company information concerning health care, advice, treatment or supplies provided to the patient, including that relating to mental illness or substance abuse. This information will be used for evaluating and administering claims for benefits.
This authorization is valid for the term of coverage. I agree that a photocopy is as valid as the original.

SIGNATURE_____ DATE: _____
Claimant