

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

Aetna is the third party claims administrator and provides the network of participating providers. Aetna does not insure this plan.

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:

