## **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

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| SECTI         | ON 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<br>Policy Number  |  |  |
| ***A<br>Healt | E SEND PAYMENT TO: Provider Me (Please attach proof of Payment) Signature   |  |  |
| SECTI         | ON 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             | 3. When did the first symptom of this condition begin?  |  |  |
| 4             | 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:   |  |  |
|               | <del></del>   |  |  |
|               |   |  |  |
|               |   |  |  |

| Is this condition the result of a   | an accident o                          | r 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  | ce departmen                           | t where it was filed.  |
| If this accident or illness has resul                                       | ted in an inpat                        | tient hospital admission, have you obtained pre-certification?   |
|   |  | ATION REQUIREMENT WILL RESULT IN A PENALTY   |
| ECTION 2 NON MEDICA   | I DEIMBI                               | IDSEMENT   |
| <u>ECTION 3. NON-MEDICA</u><br>Urgent Travel Expense, Los                   |  | e, Theft, Emergency Evacuation/Reunion, Repatriation)  |
|   |  | · · · · · · · · · · · · · · · · · · ·  |
| 1. Date of Loss   |  |  |
| 2. Please describe what ha  | ppened                                 |  |
|   |  |  |
|   |  |  |
|   |  |  |
|   |  |  |
|   |  |  |
|   |  |  |
|   |  | ust have a list attached that includes the items being claimed, date of policy requires that all non-medical losses must be reported to CIEE   |
| medical provider (if this is a c<br>Code and the Provider's Tax             | claim for medi<br>ID Number. I         | tements, reports and invoices for services and supplies and make sure your ical reimbursement) has included the following: Diagnosis Code; Procedure Please make certain that all documents indicate claimant's name, date of any questions please call CIEE at 1-888-268-6245.  |
|   | AUTHOR                                 | RIZATION FOR MEDICAL INFORMATION   |
| To all Physicians, Hospitals, or other                                      | Health Profession                      | onals:   |
| the insurance company information consubstance abuse. This information will | cerning health ca<br>be used for evalu | Health and any independent consulting health professional or auditor acting on its behalf or that are, advice, treatment or supplies provided to the patient, including that relating to mental illness nating and administering claims for benefits.  The treatment of the patient, including that relating to mental illness nating and administering claims for benefits.  The treatment of the patient o |
| SIGNATURE   |  | DATE:  |
| Claim   | ant                                    |  |