

# 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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

