

# AETNA STUDENT HEALTH CLAIM FORM

Please return this form and any attachments to:

**AETNA STUDENT HEALTH**  
**P.O. Box 981106**  
**El Paso, TX 79998**  
**Fax: 1-859-455-8650**  
**ECHS CATEGORY: NWCL**



<b>TO BE COMPLETED BY MEMBER (Please Print)</b>			
1. School Name <b>PRINCETON UNIVERSITY</b>		2. Policy Group Number <b>812847</b>	
3. Member's Aetna ID Number <b>W</b>	4. Member's Name	5. Member's Birthdate (MM/DD/YYYY)	
6. Member's Address (include ZIP CODE) <input type="checkbox"/> Address is new		7. Member's Daytime Telephone Number ( )	
8. Patient's Name	9. Patient's Aetna ID Number <b>W</b>	10. Patient's Birthdate (MM/DD/YYYY)	11. Patient's Relationship To Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
12. Are your or any family members' expenses covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan?  <input type="checkbox"/> Yes If Yes, go to Section 13 <input type="checkbox"/> No If No, go to Section 17		13. List policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:  <b>Note: If you do have another insurance plan, Aetna Student Health is considered your secondary plan.</b>	
14. Member's ID Number	15. Member's Name	16. Member's Birthdate (MM/DD/YYYY)	
17. Is claim related to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, go to Sections 18-24 If No, skip to Section 25			
<b>18. COMPLETE THIS SECTION FOR AN ACCIDENT CLAIM</b>		<b>25. COMPLETE THIS SECTION FOR MEDICAL/DENTAL CLAIMS</b>	
19. Summary of the Accident:		<b>Instructions: Check claim type in Section 26. Go to corresponding section. Complete claim form with signature and date. Attach receipt as described in Section 29. Send claim to Aetna Student Health at address located at top right side of this form.*</b>	
20. Location where accident occurred:		26. <input type="checkbox"/> Preventative Dental (Go to Section 29)	
21. Was injury due to practice/play of NCAA sponsored sport? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, answer Section 22. If No, skip to Section 23.		<input type="checkbox"/> Vaccination (Go to Section 29)	
22. Name of Sport?		<input type="checkbox"/> Mental Health (No referral required) (Go to Section 29)	
23. Was injury work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Complimentary Medicine/Physical Therapy (Go to Section 27)	
24. Is condition due to an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please attach auto voucher.</i>		<input type="checkbox"/> Other (Go to Section 28)	
<b>GO TO SECTION 29 TO COMPLETE FORM</b>		<b>27. COMPLIMENTARY MEDICINE / PHYSICAL THERAPY CLAIM</b>	
29. Attach itemized bills. The bills must include: - patient's name - condition being treated - dates(s) of service(s) - type of service - proof of payment  If you have submitted a request for benefits to another insurance plan, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.  Retain copies of your bills for your record. Sign and date below.		Were you treated at University Health Services for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No  Did you receive a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<b>28. OTHER CLAIM</b>	
		Were you treated at University Health Services for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No  Did you receive a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No  Were services obtained outside the Princeton vicinity**? <input type="checkbox"/> Yes <input type="checkbox"/> No  Were services obtained during a break period? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SIGNATURE _____		DATE _____	

\* Claims can be mailed to address located at top right side of this form *or* faxed directly to 1-859-455-8650.

\*\* If outside of Mercer, Middlesex or Somerset Counties in NJ and Bucks County in PA, no referral needed.