AETNA STUDENT HEALTH CLAIM FORM

University Health Services

Please return this form and any attachments to:

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

TO BE COMPLETED BY MEMBER (Please Print)

1. School Name: **PRINCETON UNIVERSITY**

2. Policy Group Number: **812847**

3. Member's Aetna ID Number: **W**

4. Member's Name:

5. Member's Birthdate *(MM/DD/YYYY)*:

6. Member's Address (include ZIP CODE) ☐ Address is new

7. Member's Daytime Telephone Number: ( )

8. Patient's Name:

9. Patient's Aetna ID Number: **W**

10. Patient's Birthdate *(MM/DD/YYYY)*:

11. Patient's Relationship To Member: ☐ Self ☐ Spouse ☐ Child ☐ 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?

☐ Yes If Yes, go to Section 13 ☐ 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:

Note: If you do have another insurance plan, Aetna Student Health is considered your secondary plan.

14. Member's ID Number:

15. Member's Name:

16. Member's Birthdate *(MM/DD/YYYY)*:

17. Is claim related to an accident? ☐ Yes ☐ No If Yes, go to Sections 18-24 If No, skip to Section 25

18. COMPLETE THIS SECTION FOR AN ACCIDENT CLAIM

19. Summary of the Accident:

20. Location where accident occurred:

21. Was injury due to practice/play of NCAA sponsored sport?

☐ Yes ☐ No If Yes, answer Section 22. If No, skip to Section 23.

22. Name of Sport?

23. Was injury work related?

☐ Yes ☐ No

24. Is condition due to an auto accident?

☐ Yes ☐ No

If yes, please attach auto voucher.

GO TO SECTION 29 TO COMPLETE FORM

25. COMPLETE THIS SECTION FOR MEDICAL/DENTAL CLAIMS

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.*

26.
- ☐ **Preventative Dental** (Go to Section 29)
- ☐ **Vaccination** (Go to Section 29)
- ☐ **Mental Health** (No referral required) (Go to Section 29)
- ☐ **Complimentary Medicine/Physical Therapy** (Go to Section 27)
- ☐ **Other** (Go to Section 28)

27. COMPLIMENTARY MEDICINE / PHYSICAL THERAPY CLAIM

Were you treated at University Health Services for this condition?

☐ Yes ☐ No

Did you receive a referral? ☐ Yes ☐ No

28. OTHER CLAIM

Were you treated at University Health Services for this condition?

☐ Yes ☐ No

Did you receive a referral? ☐ Yes ☐ No

Were services obtained outside the Princeton vicinity**? ☐ Yes ☐ No

Were services obtained during a break period? ☐ Yes ☐ No

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 submited 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.

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.