PRINCETON UNIVERSITY CLAIM FORM

Please return this form and any attachments to:

AETNA STUDENT HEALTH
P.O Box 15708
Boston, MA 02215-0014

TO BE COMPLETED BY MEMBER (Please Print)

1. School Name

2. Policy Group Number

3. Member's Aetna ID Number

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

10. Patient's DOB (MM/DD/YYYY)

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

12. Are any family members expenses covered by another group health plan, group pre-payment plan, no fault auto insurance, Medicare or any federal, state or local government plan?

☐ Yes ☐ No

13. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:

14. MEMBER'S ID NUMBER

15. MEMBER'S NAME

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

17. Is claim related to an accidental injury? ☐ YES ☐ NO If Yes, follow sections 18-25. If No, skip to section 26.

18. COMPLETE THIS SECTION FOR AN ACCIDENT CLAIM

19. Summary of the Accident:

21. Location where accident occurred:

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

☐ YES ☐ NO If Yes, answer section 23 If No, skip to section 24.

23. Name of Sport?

24. Was injury work related?

☐ YES ☐ NO

25. Is condition due to an auto accident?

☐ YES ☐ NO

If yes, please attach auto voucher.

GO TO SECTION 31 To Complete Claim Form

26. COMPLETE THIS SECTION FOR A SICKNESS CLAIM

Instructions: Check claim type in section 27, then fill out responding section, skip to section 31 for signature, attach receipt, send claim to ASH at address located top right side of this form.

27. ☐ **Preventative Dental (Go to Section 31).**

☐ **HPV Vaccination (Go to Section 31).**

☐ **Outpatient Mental Health (Go to Section 28).**

☐ **Complimentary Medicine (Go to Section 29).**

☐ **Other (Go to Section 30).**

28. OUTPATIENT MENTAL HEALTH CLAIM

Were you treated in the Health Service for this condition *(either UHS or CPS)?:*

☐ YES ☐ NO

If Yes, by whom were you seen?:

Did you receive a referral?: ☐ YES ☐ NO

29. COMPLIMENTARY MEDICINE / PHYSICAL THERAPY CLAIM

Were you treated in the Health Service for this condition*?:*

☐ YES ☐ NO

If Yes, By Whom were you seen?:

Did you receive a referral?: ☐ YES ☐ NO

Physical Therapy and Complimentary Medicine referrals must be renewed after 10 visits for continued treatment.

30. OTHER CLAIM

Were you treated in the Health Service for this condition*?:*

☐ YES ☐ NO

If Yes, By Whom were you seen?:

Did you receive a referral?: ☐ YES ☐ NO

31. Please Send Payment To: ☐ PROVIDER ☐ ME (**Please Attach Proof of Payment**) SIGNATURE ____