THE WORLD BANK GROUP

CLAIM FOR HOSPITAL AND OTHER MEDICAL EXPENSES

If illness or injury occurred while at work, contact the Workers Compensation Insurance Representative, ext.30807, BEFORE filling out this form.

PART I - TO BE COMPLETED BY STAFF MEMBER OR RETIRED STAFF(hereinafter: staff member) OR PATIENT IF COVERED SEPARATELY FROM STAFF MEMBER

1. Patient's Name (Last, First, M.I)	2. Patient's Relationship to Staff Member	3. Patient's Birthday

4. Sex	5. If claim is for son/daughter, was the child under 26 at the time of expense was incurred?

6. Staff Member's (or Surviving spouse's) Name (Last, First, M.I) IF NOT PATIENT	7. Staff Member's (or Surviving spouse's) Birth date - IF NOT PATIENT	8. Staff Member's UPI

9. Nature of illness, injury or service

10. If claim is for accidental injury, enter date and indicate where and how occurred	11. Is claim for second surgical opinion?

12. Is patient, other than staff member, employed?	13. Name and Address of Employer in Item 12

14. Is patient covered by another group, student, government (e.g. Medicare) or employment related Medical Plan?	◯ Yes	◯ No

Medical Plan Name	Group No.	Name and Address of Carrier

I authorize the release to the World Bank Group Medical Insurance Plan administrator, to the World Bank Group or their representative, any information including medical, employment and benefit information required for claim processing or plan administration. Such information shall be released directly to the World Bank Group only in circumstances where fraud or misconduct is believed to have occurred. This authorization to release information is valid for two years after the date signed. A copy of this authorization shall be valid as the original. If the staff member is incapacitated or deceased, the Personal Representative or next of kin must sign.

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Patient's Signature (Parent/Guardian, if minor; leave blank if staff member) Date

I certify that the statements here and attached are complete and accurate. As the patient, I authorize the release of information as described above.

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Staff Member's Signature Date

PART II – TO BE COMPLETED BY ATTENDING PHYSICIAN (in lieu of itemized bill)

15. Physician's Name (Last, First, M.I.)	16. Mailing Address (Street, city, State, Postal/Zip Code)

17. Is treatment result of occupational illness or injury?	☐ Yes	☐ No

18. Date symptoms first appeared or accident happened	Enter brief description and dates

19. Physician's S.S.N. or T.I.N	20. Physician's License No.	21. Physician's Telephone No.	22. Date you were first consulted on this condition?

Keep a copy of completed form for your records

23. Diagnosis and current condition

24. Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, indicate when and describe

25. Is patient still under your care for this condition? ☐ Yes ☐ No

Date of Service	Place	ICD-9 Code	Description	Charge

26. I certify that the procedures as indicated by date have been completed ---------- Signature ---------- Date

Return completed form to: mclaims@aetna.com OR Aetna/World Bank MIP Claims P.O.Box 14199 Lexington, KY 40512-4199 USA OR via internal mail to MIP Claims MSN MC-C3-309.