# Aetna US Healthcare — Dental Benefits Request

- Complete Sections 1 - 6.
- Sign Section 7 to have benefits paid to the dentist.
- Complete Employee Information on reverse side.
- If charges are only for examination, cleaning or X-rays, itemized bills may be submitted instead of having the dentist complete the provider statement on the reverse side. The bills must include:
  - patient's name
  - relationship to employee
  - date of service
  - type of service rendered
  - condition being treated

  If this information is missing, write it on the bill and sign your name.
- If you are covered by other dental coverage attach a copy of the bills you have submitted to the other plan and the explanation of benefits you received from the other plan.
- Incomplete forms will delay payment.
- **Send the completed benefit request and the bills to the Aetna office that services your employer.**

**1. Employer Information**

Name (as shown on ID card)

Policy/Group Number

**2. Employee Information**

Social Security Number ___ ___

Name

Birthdate (MM/DD/YYYY)

☐ Active ☐ Retired
Date of Retirement

Address (include zip code) ☐ Address is new

Daytime Telephone Number
( )

**3. Patient Information**

Social Security Number ___ ___

Name

Birthdate (MM/DD/YYYY)

Relationship to Employee
☐ Self ☐ Spouse ☐ Child ☐ Other

Address (if different from employee)

Sex
☐ Male ☐ Female

Full Time Student
☐ No ☐ Yes

Expected Graduation Date

School Name

Marital Status
☐ Married ☐ Single

Is patient employed?
☐ No ☐ Yes
Date of Retirement

Name/Address of Employer

**4. Other Coverage Information**

Are 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? ☐ No ☐ Yes

If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator

Member's Social Security Number ___ ___

Member's Name

Member's Birthdate (MM/DD,YYYY)

**5. Claim Information**

Is claim related to an accident?
☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm

Is claim related to employment?
☐ No ☐ Yes

Description of Accident

**6. Release**

To all providers of dental care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting dental professionals and utilization review organizations with whom Aetna has contracted, information concerning dental care, advice, treatment or supplies provided the patient. This information will be used to evaluate claims for dental benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

**7. Assignment**

I authorize payment of dental benefits to the dentist or supplier of service.

Patient's or Authorized Person's Signature _____ Date _____

For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. **Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

# Dentist's Statement

**Employee Information**

Name

Social Security Number

- Complete Sections 1 - 18.
- Submit X-rays with:
  - treatments involving gold restorations, crowns, implants or bridgework X-rays

  may be requested for other service.

| 1. Patient's Name | 2. Patient's Birthdate |
|---|---|
| | |

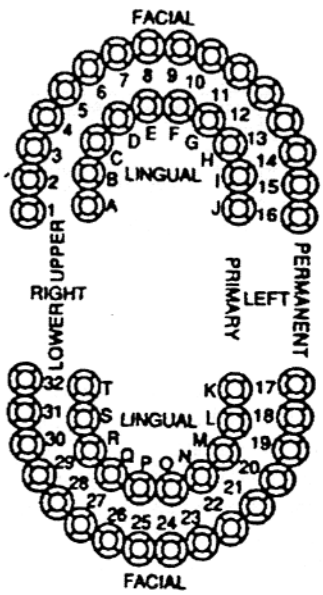
| 3. Dentist's Name & Address (include zip code) | 4. Telephone No. | 5. Dentist License No. |
|---|---|---|
| | ( ) | |

6. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.

| 7. First Visit Date Current Series | 8. Place of Treatment | 9. Radiographs or models enclosed? |
|---|---|---|
| | ☐ Office ☐ Hosp. ☐ ECF ☐ Other | ☐ No ☐ Yes How many? |

| Is treatment result of: | No | Yes | If yes, enter brief description and dates |
|---|---|---|---|
| 10. occupational illness or injury? | | | |
| 11. auto accident? | | | |
| 12. other accident? | | | |
| 13. Are any services covered by another plan? | | | |
| 14. If prosthesis, is this initial placement? | | | If no, date of prior placement and reason for replacement |
| 15. Is treatment for orthodontics? | | | Date appliance placed: _____ Initial Appliance Fee: _____<br>No. of months of treatment: _____ Monthly Fee: _____<br>Mos. of treatment remaining: _____ Total Case Fee: _____ |

16. To expedite claim handling, identify all missing teeth with "X"




17. Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. Use charting system shown.

| Tooth # or Letter | If Previously Extracted, Give Date | Surface | Description of Service (x-rays, prophylaxis, materials used, etc.) | Date Service Performed Mo. Day Yr. | Procedure Number | Fee |
|---|---|---|---|---|---|---|
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18. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.

Dentist's Signature _____ Date _____

Total charge $_____

Amount paid $_____

Balance due $_____