

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 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.

_	If this information is	missing, write it on the bill	and sign	n your name.						
1.	Employer Information	Name (as shown on ID card)						Policy/Group Number		
2.	Employee Information	Social Security Number Active Retired		Name	Coods) Address is now	Birthdate (MM/DD/YYYY)				
_		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								
		Sex Male Female	Full Time	Student Yes	Expected Graduation Date	School Nan	ne	Marital Status Married Single		
_		s 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 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 Description of Accident	s, date _		time	- mail and a second	ampm	Is claim related to employment?		
6.	Release	To all providers of dental of You are authorized to provide claim administrators and conformation concerning derical claims for dental benefits. A claim for the purpose of resofthe policy or contract unauthorization upon request Patient's or Authorized Personnel.	ide Aet onsultin ntal care Aetna n viewing der who and ago	ng dental profese, advice, treating provide the graph the experience ich a claim has ree that a photo	ssionals and utilization ment or supplies provi e employer named abo e and operation of the been submitted. I kno graphic copy of this a	ded the parties of th	rganizations with who attent. This information my benefit calculation contract. This authori- save a right to receive on is as valid as the or	om Aetna has contracted, on will be used to evaluate used in payment of this zation is valid for the term a copy of this riginal.		
7.	Assignment	I authorize payment of deni								
3C-4	3-2 (11-98) AIFS	Patient's or Authorized Person's Signature								

Dentist's Statement

• Complete Sections 1 - 18.

Employee Information	
Name	
Social Security Number	_
occar security Number	

- Submit X-rays with:
 - treatments involving gold restorations, crowns, implants or bridgework X-rays

2. Petient's Name & Address (include zip code) 4. Telephone No. () 6. Enrice the largoyer identifying number in be used for 1099 reporting purposes. You are required under surhority of law to furnity your trappage in dentifying number. 7. First Viral Date Current Series 8. Place of Treatment 9. Radographs or models endos 10. Over If you surpose in dentifying number. 11. and a socient? 11. and a socient? 11. and a socient? 11. and a socient? 11. If you surpose is socient is a socient in the socient						may	be requested for o	other service.				
Comment Comm	1. Patient's Name								2. Patient's Birthda	te		
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