Dental Benefits – Claim Instructions

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.
California Residents: 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.
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.
Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE EMPLOYEE

1. Complete items one (1) through twenty-seven (27) in full. Be certain to sign the authorization to release information block (28).
2. If you wish to have your benefits for this claim paid directly to your dentist, sign the block (29).

   If total charges for the planned course of treatment are expected to exceed the minimum Predetermination dollar amount stated in your dental plan booklet, it is suggested you file for Predetermination of Benefits. Aetna Dental™ will notify your dentist of the benefits payable.

NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR DENTAL BOOKLET FOR DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND COPAYMENT INFORMATION, AND LIMITATIONS AND EXCLUSIONS.

TO THE DENTIST

1. COMPLETED SERVICES — Check the box noted "STATEMENT OF SERVICES RENDERED" and complete items 30 through 46. When entering the treatment plan on the form, please indicate a separate fee for each individual service rendered.

2. PREDETERMINATION OF BENEFITS — If total charges for this claim are to exceed the minimum Predetermination dollar amount indicated in the employee's Dental Plan Booklet (and treatment is not emergency in nature), Predetermination of Benefits is suggested. Check the box marked "PRE-TREATMENT ESTIMATE", and complete items 30 through 46.

NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE EMPLOYEE, DENTIST AND INSURANCE COMPANY CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.

3. If the employee indicates that benefits should be paid directly to the dentist, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

***X-rays taken for metal restorations and crowns should be submitted with treatment plan. They may also be requested for other services. X-rays will be reviewed by practicing Dentists and returned promptly.**

TO THE EMPLOYEE & DENTIST

Send the completed benefits request and the bills to: **Aetna Dental™**
P.O. Box 14094
Lexington, KY 40512-4094

Dental Benefits Request

Mail to: **Aetna Dental™**
P.O. Box 14094
Lexington, KY 40512-4094

TO BE COMPLETED BY EMPLOYEE

1. Employer's Name **UNIVERSITY OF HARTFORD**			2. Policy/Group Number **724328** Branch Number
3. Employee's Social Security Number	4. Employee's Name		5. Employee's Birthdate (MM/DD/YYYY)
6. ☐ Active ☐ Retired Date of Retirement	7. Employee's Address (include zip code) ☐ Address is new		8. Employee's Daytime Telephone Number ( )
9. Patient's Name	10. Patient's Social Security Number	11. Patient's Birthdate (MM/DD/YYYY)	12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from employee)	14. Patient's Sex ☐ Male ☐ Female 15. Full Time Student ☐ No ☐ Yes	16. Patient's Expected Graduation Date	17. Name of School City
18. Patient's Marital Status ☐ Married ☐ Single	19. Is patient employed? ☐ No ☐ Yes	20. Name & Address of Employer	
21. 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		22. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
23. Member's Social Security Number	24. Member's Name		25. Member's Birthdate (MM/DD/YYYY)
26. Is claim related to an accident? ☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm			27. Is claim related to employment? ☐ No ☐ Yes

28. 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 _____

29. I authorize payment of dental benefits to the dentist or supplier of service.
Patient's or Authorized Person's Signature _____ Date _____

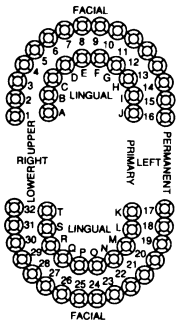
TO BE COMPLETED BY DENTIST

30. This is a ☐ Request for Pre-Treatment Estimate ☐ Statement of Services Rendered

31. Dentist's Name & Address (include zip code)	32. Telephone No. ( )		33. Dentist License No.
	34. 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.		
	35. First Visit Date Current Series	36. Place of Treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other	37. Radiographs or models enclosed? ☐ No ☐ Yes How many?

Is treatment result of:	No	Yes	If yes, enter brief description and dates
38. occupational illness or injury?			
39. auto accident?			
40. other accident?			
41. Are any services covered by another plan?			
42. If prosthesis, is this initial placement?			If no, date of prior placement and reason for replacement
43. Is treatment for orthodontics?			Date appliance placed: _____ Initial Appliance Fee: _____ No. of months of treatment: _____ Monthly Fee: _____ Mos. of treatment remaining: _____ Total Case Fee: _____

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



45. 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 MM DD YYYY	Procedure Number	Fee
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46. 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 $_____