aetna℠

Dental Benefits Request

Mail to: Aetna Dental
PO Box 14094
Lexington, KY 40512-4094

TO BE COMPLETED BY EMPLOYEE – USE BLACK INK ONLY

1. Employer's Name			2. Policy/Group Number
3. Employee's Aetna ID 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 Aetna ID 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 Gender ☐ Male ☐ Female / 15. Full Time Student ☐ No ☐ Yes	16. Patient's Expected Graduation Date	17. Name of School and City
18. Patient's Marital Status ☐ Married ☐ Single	19. Is patient employed? ☐ No ☐ Yes	20. Name and Address of Employer	
21. Is claim related to an accident? ☐ No ☐ Yes If Yes, date _____ time _____ ☐ am ☐ pm			22. Is claim related to employment? ☐ No ☐ Yes
23. 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		24. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
25. Member's ID Number	26. Member's Name		27. Member's Birthdate *(MM/DD/YYYY)*

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 _____

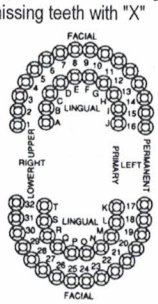
TO BE COMPLETED BY DENTIST – USE BLACK INK ONLY

30. This is a request for:
☐ Pre-Treatment Estimate Predetermination/Preauthorization Number _____ ☒ Statement of Services Rendered

31. Dentist's Name & Address (include ZIP Code) Scott H. Leaf, D.D.S. 9316-C Old Keene Mill Rd. Burke, Virginia 22015	32. National Provider Identifier 1346457983	33. Dentist License No. 401005821	34. Telephone Number (703) 455-9683
	35. 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. 27-0773127		
	36. First Visit Date Current Series	37. Place of Treatment ☒ Office ☐ Hosp. ☐ ECF ☐ Other	38. Radiographs or models enclosed? ☐ No ☐ Yes How many?

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

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



46. 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

47. 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 _____

48. National Provider Identification
1346457983

Total charge $_____
Amount paid $_____
Balance due $_____

GC-8-13 (1-13) J