Dentist's Statement

Aetna Global Benefits®

Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

- ***This form should be completed and submitted if an itemized bill is not provided to accompany the Claim Form (GR-68069) and/or if treatment is for other than an examination, cleaning or x-rays. The Summary of Reimbursement section of the Dental Benefit Request form will identify the party to whom benefit payments should be made payable/sent.***
- Fully itemized bills and receipts should include: Patient's name and relationship to employee, Provider Name/address/telephone number, condition being treated, date of service, type of service rendered and the tooth or teeth affected by treatment, amount charged, and procedures performed. If this information is not shown, you may hand-write it on the bill/receipt and sign your name.
- If fully itemized bills are not provided or if services rendered are for other than examinations, cleanings or x-rays, Provider's should complete this form and attach it to all bills and a completed **Claim Form (GR-68069)**, and mail them to the address on the back of the member's insurance Identification Card or **Aetna Global Benefits, P.O. Box 30258, Tampa, FL 33630-3258, U.S.A.**
- If this is for a pre-treatment estimate, leave the date blank for those services that have not been completed. Our estimate and your X-rays will be returned to you promptly. Estimates are subject to deductible and plan maximums and may be reduced by payments made before these services are rendered. The estimate is based on the assumption the patient will receive the services while covered and the treatment plan does not change. Actual payment may differ from the estimate.

  Indicate date of treatment only when treatment has been completed. Describe any changes in the treatment plan.
- Submit X-rays with:
  - request for pre-treatment estimates
  - treatments involving gold restorations, crowns, implants or bridgework.
- X-rays may be requested for other service.
- Identify any missing teeth and date extracted on the tooth chart below.

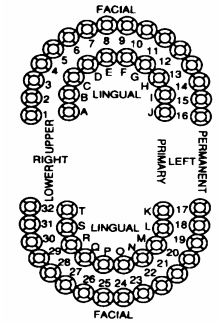
1. Employee's Name	2. Employee's Social Security/I.D. Number
3. Patient's Name	4. Patient's Birthdate *(mm/dd/yyyy)*

5. This is a ☐ Request for pre-treatment estimate ☐ Statement of services rendered

6. Dentist's Name & Address (include zip code)	7. Telephone No. ( )	8. Dentist License No.
	9. If applicable, enter the taxpayer identifying number to be used for U.S. 1099 reporting purposes. You are required under authority of U.S. law to furnish your taxpayer identifying number.	
	10. First Visit Date Current Series	11. Place of Treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other
		12. Radiographs or models enclosed? ☐ No ☐ Yes How many?

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

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



20. 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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21. 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 $_____

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.

Please Retain A Copy For Your Records