Claim for Dental Benefits

MAIL TO: Aetna U.S. Healthcare
PO Box 14094
Lexington, KY 40512-4094
1-877-238-6200

NEW JERSEY STATE DENTAL EXPENSE PLAN

CLAIM SERVICES PROVIDED BY AETNA U.S. HEALTHCARE

TO BE COMPLETED BY EMPLOYEE

1. Patient Name	2. Relationship To Employee: Self / Spouse / Child / Other	3. Sex: M / F	4. Patient Birthdate: MM / DD / YYYY	5. Payor Code: 60054

6. Employee Name: First / Middle / Last	Employee's Birthdate: MM / DD / YYYY	7. Employee Social Security No.	8. Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Separated	Spouse's Birthdate: MM / DD / YYYY

9. Employee Mailing Address	10. Status: ❑ Active ❑ Leave of Absence ❑ COBRA
City, State / Zip	Employer Name:

11. Group Number: 812310	12. Branch	13. Are Other Family Members Employed? No ❑ Yes ❑ — Employee Name / Soc. Sec. No.	14. Name and Address of Employer in Item 13.

15. Is Patient Covered by Another Dental Plan? No ❑ Yes ❑ If yes, please give:
Dental Plan Name — Name and Address of Carrier

15a. If patient is a Dependent Child are the Legal Parents divorced or separated from each other? No ❑ Yes ❑

15b. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

____________________ Signed (Patient, or Parent if minor) __________ Date

15c. I hereby certify that the above information is correct.

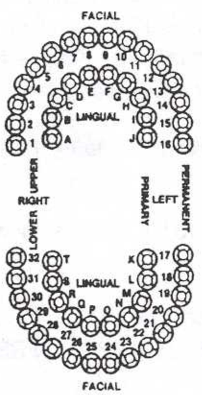
____________________ Employee Signature __________ Date

TO BE COMPLETED BY DENTIST

16. Dentist Name: First / Middle / Last	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
17. Mailing Address	25. Is treatment result of auto accident?			
	26. Other accident?			
City, State / Zip	27. Are any services covered by another plan?			
18. Dentist Soc. Sec. or T.I.N. / 19. Dentist License No. / 20. Dentist Phone No.	28. If prosthesis, crown or inlay, is this initial placement?			(If no, reason for replacement) — 29. Date of prior placement
21. First Visit Date Current series / 22. Place of Treatment: Office / Hosp / ECF / other / 23. Radiographs or Models Enclosed: No / Yes / How Many?	30. Is treatment for orthodontics?			If services already commenced enter — Date appliances placed — Mos. Treatment remaining

Dentist - Check One
❑ Pretreatment estimate
❑ Statement of actual services

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN

Tooth No. Or Ltr	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Performed MM	DD	YYYY	Procedure Number	FEE	ADMINISTRATIVE USE ONLY
		TOTAL FEE CHARGED						

TO BE COMPLETED BY DENTIST

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 THESE PROCEDURES.

DENTIST'S SIGNATURE: ____________________ **DATE:** ________

DIRECTION TO PAY BENEFITS TO DENTIST

I HEREBY DIRECT BENEFITS PAYABLE TO THE ATTENDING DENTIST.

EMPLOYEE'S SIGNATURE: ____________________ **DATE:** ________

Administrative Use Only

Patient's Eligible Date
Mo.______ Day______ Yr.______

Patient's Effective Date
Mo.______ Day______ Yr.______

Patient's Termination Date
Mo.______ Day______ Yr.______

Verified by________________

Date Verified Mo.______ Day______ Yr.______

IMPORTANT - to insure the proper processing of this claim, please check the accuracy of the following:
Employee Questions - 1 through 15a, b & c
Dentist Questions - 16 through 32, dates of services, & procedure numbers
If initial prosthesis, list date(s) of extraction(s) for teeth being replaced.

GC-14848 (8-01)