



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
 - date of service
 - relationship to employee
 - type of service rendered
 - condition being treated

If this information is missing, write it on the bill and sign your name.

- You may submit a request for a pre-treatment estimate of benefits if you anticipate extensive dental work. Your booklet describes the pre-treatment estimate. Actual payment may differ from the estimate.
- 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 benefits request and the bills to:**

**Aetna Claim Office
P.O.Box 14079
Lexington, KY 40512**

Claim Questions: **call toll-free at 1-888-553-3449.**

1. Employer	Name COX ENTERPRISES, INC.		Policy/Group Number 779409
2. Employee Information	Social Security Number	Name	Birthdate (MM, DD, YYYY)
	<input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement	Address (include zip code) <input type="checkbox"/> Address is new	Daytime Telephone Number ()
3. Patient Information	Social Security Number	Name	Birthdate (MM, DD, YYYY)
	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Address (if different from employee)
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	
	Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> 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/Shield, etc.), Medicare or any federal, state or local government plan? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If "yes", date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm		Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Description of Accident		
6. Release	<p>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.</p> <p>Patient's or Authorized Person's Signature _____ Date _____</p>		
7. Assignment	I authorize payment of dental benefits to the dentist or supplier of service.		
	<p>Patient's or Authorized Person's Signature _____ Date _____</p> <p>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 state prison, and substantial civil penalties. Many other states have similar laws. Attention 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.</p>		

