Claim for Dental Benefits

NEW JERSEY STATE DENTAL EXPENSE PLAN

CLAIM SERVICES PROVIDED BY AETNA U.S. HEALTHCARE

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

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	12. Branch	13. Are Other Family Members Employed? No ❑ Yes ❑ (Employee Name / Soc. Sec. No.)	14. Name and Address of Employer in Item 13.
812310			

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	17. Mailing Address	City, State / Zip

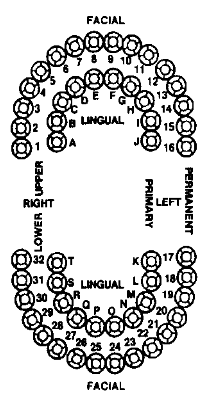
18. Dentist Soc. Sec. or T.I.N.	19. Dentist License No.	20. Dentist Phone No.

21. First Visit Date Current series	22. Place of Treatment: Office / Hosp / ECF / other	23. Radiographs or Models Enclosed: No / Yes / How Many?

Question	No	Yes	If yes, enter brief description and dates
24. Is treatment result of occupational illness or injury?			
25. Is treatment result of auto accident?			
26. Other accident?			
27. Are any services covered by another plan?			
28. If prosthesis, crown or inlay, is this initial placement?			(If no, reason for replacement) 29. Date of prior placement
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)

NEW JERSEY STATE DENTAL EXPENSE PLAN
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.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY PAYMENT OF YOUR CLAIM.

TO THE EMPLOYEE

1. Complete items one (1) through fifteen (15a) in full. Be certain to sign the authorization to release information block and the certification block (15b and 15c).

2. If you wish to have your benefits for this claim paid directly to your dentist, sign the "Direction to pay benefits to dentist" block located below the dentist certification.

   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 required that you file for Predetermination of Benefits. Aetna U.S. Healthcare 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 A DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLES, COINSURANCE INFORMATION, AND LIMITATIONS AND EXCLUSIONS.

TO THE DENTIST

1. COMPLETED SERVICES — Check the box noted "STATEMENT OF ACTUAL SERVICES" and complete items 16 through 32. When entering the treatment plan on the form, please indicate a *separate* fee for each individual service rendered. When the work is finished, sign the form and mail to the address shown in the upper right hand corner of the reverse side of this form.

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 required. Check the box marked "PRETREATMENT ESTIMATE", and complete items 16 through 32. **Please be sure to answer questions 28 and 29 if the claim includes metal restorations, crowns, bridgework or dentures.***

   The completed form should be sent to the address shown in the upper right hand corner of the reverse side of this form. Aetna U.S. Healthcare will notify you of the benefits payable for this course of treatment.

   When treatment has been completed, fill in the date each service was provided, sign the form and return to the address shown in the upper right hand corner of the reverse side of this form for payment.

NOTE: PREDETERMINATION OF BENEFITS IS 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 transaction 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 and returned promptly.