

AmeriCorps Dental Benefits – Claim Instructions

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is quilty of a crime and may be subject to fines and confinement in prison.

Attention California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is quilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Ohio and 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.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS. TO THE MEMBER

- Complete blocks 1–16 in full.
- 2. Complete blocks 17-18 only if other dental coverage exists.
- 3. Be certain to sign the authorization to release information in block 19.
- 4. If you wish to have your benefits for this claim paid directly to your dentist, sign block 20.

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 suggested you file for Predetermination of Benefits. Aetna Dental 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 DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND COPAYMENT INFORMATION, AND LIMITATIONS AND EXCLUSIONS.

TO THE DENTIST

- COMPLETED SERVICES Check the box noted "STATEMENT OF SERVICES RENDERED" and complete blocks 21-39. When entering the treatment plan on the form, please indicate a separate fee for each individual service rendered.
- PREDETERMINATION OF BENEFITS If total charges for this claim are to exceed the minimum Predetermination dollar amount indicated in the member's Dental Plan Booklet (and treatment is not emergency in nature), Predetermination of Benefits is suggested. Check the box marked "PRE-TREATMENT ESTIMATE", and complete blocks 21-39

NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE MEMBER, 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, these benefits will be sent directly to you with a copy of the transaction to the member.

*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 by practicing Dentists and returned promptly.

TO THE EMPLOYEE & DENTIST

Send the completed benefits request and the bills to:

SRC, an Aetna Company Attn: Claim Department PO Box 14094 Lexington, KY 40512-4094 Fax to: 1-859-455-8650 Phone: 1-888-772-9682

GC-15921 (7-09)



**Aetna* AmeriCorps Dental Benefits Request

Mail to:

SRC, an Aetna Company Attn: Claim Department PO Box 14094

Lexington, KY 40512-4094 Fax to: 1-859-455-8650 Phone: 1-866-292-3374

TO	BE COMPLETED BY MEMBER													
	AmeriCorps Program Name						_				2. Policy	//Group Numbe		
Amenosipe i logialii valile											z. ruit)	Worden Marriage		
3.	Member's Aetna ID Number	ember's Aetna ID Number 4. Member's Na				me						Member's Birthdate (MM/DD/YYYY)		
6.	Member's Address (include zip cod	mber's Address (include zip code) Address is new										7. Member's Daytime Telephone Number		
8.	Patient's Name 9. Patient's Aetho					a ID Number 10. Patient's Birt			Birthdate (MM/DD	D/YYYY)		nt's Relationship to	o Employee	
12.	Patient's Address (if different from member)					13. Patient's Gender ☐ Male ☐ Female					14. Patie	nt's Marital Status	117	
15. Is claim related to an accident?												im related to Ame		
	□ No □ Yes If Yes, date					time					\square N	o Yes		
17.	Are any family members' expenses covered by another group heal plan (Blue Cross- Blue Shield, etc.), no fault auto insurance, Medic local government plan?										policy or contract number(s) and name/address ator:			
	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 Date													
	I authorize payment of dental bene ient's or Authorized Person's Signature		entist or su	pplier o	t service						Date			
_	BE COMPLETED BY DENTIST	ule		_			_				Date			
_														
21.	Request for Pre-Treatment Est	This is a request for: ☐ Request for Pre-Treatment Estimate												
22	Dentist's Name & Address (include zip code) 23. National Provider Identifier 24. Dentist License No.										25. Telephone Number			
					la	nter the taxpayer identif w to furnish your taxpa irst Visit Date Current S	yer ide	entifying i	number. Place of Treatme	ent Hosp.	29. Radio	ographs or models	a production framework framework	
In treatment result of					If Voc	If Yes, enter brief description and dates.						How many?		
1002 NASSA				11 165,	emer brief description a	allu uc	iles.	***************************************						
31.	auto accident?													
32.	other accident?													
	Are any services covered by anoth			10										
34.	If prosthesis, is this initial placement	prosthesis, is this initial placement? If No, date of prior placement and reason for replacement.									10			
35.	Is treatment for orthodontics?				No. of	Date appliance placed: Initial Applia No. of months of treatment: Monthly Fee Mos. of treatment remaining: Total Case F						9:		
36.	To expedite claim handling,	37. Exam	nination and	treatm	ent plan.	List in order from tooth	no. 1	through	tooth no. 32. Use	e charting sy	stem show	vn.		
	identify all missing teeth with "X"	If Previously Tooth # Extracted,				Description of Service	TOTAL CONTROL OF THE PARTY OF T		Date Service		Procedure			
		or Letter	Give Date		Surface					MM DD	YYYY	Number	Fee	
	G G Lingual (G s													
	P P P P													
	AIGHT BLEFT													
	GT GE UNGUAL GT G													
	~ B. C.													
	FACIAL													
38	I hereby certify that the procedures	s as indicate	ed by date	nave be	en comp	leted and that the fees	submi	tted are t	he 48. National	Provider Ide	ntification	Total charge	\$	
	actual fees I have charged this pat											Amount paid		
	Dentist's Signature					Date						Dalamas di	c	