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 guilty of a crime and may be subject to fines and confinement in prison.

Attention California, 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 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 guilty 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 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 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

1. 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 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

1. 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.
2. 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
P.O. Box 23907
Columbia, SC 29224-3907
Fax to: 1-803-333-1402
Phone: 1-888-772-9682

Aetna

AmeriCorps Dental Benefits Request

Mail to: SRC, an Aetna Company
Attn: Claim Department
P.O. Box 23907
Columbia, SC 29224-3907
Fax to: 1-803-333-1402
Phone: 1-888-772-9682

TO BE COMPLETED BY MEMBER

1. AmeriCorps Program Name			2. Policy/Group Number
3. Member's Aetna ID Number	4. Member's Name		5. Member's Birthdate *(MM/DD/YYYY)*
6. Member's Address (include zip code) ☐ Address is new			7. Member's Daytime Telephone Number ( )
8. Patient's Name	9. Patient's Aetna ID Number	10. Patient's Birthdate *(MM/DD/YYYY)*	11. Patient's Relationship to Member ☐ Self ☐ Child
12. Patient's Address (if different from member)		13. Patient's Sex ☐ Male ☐ Female	14. Patient's Marital Status ☐ Married ☐ Single
15. Is claim related to an accident? ☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm			16. Is claim related to AmeriCorps duties? ☐ No ☐ Yes
17. Are your expenses covered by another group health plan, group pre-payment plan (Blue Cross- Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes		18. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	

19. 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 _____

20. I authorize payment of dental benefits to the dentist or supplier of service.
Patient's or Authorized Person's Signature _____ Date _____

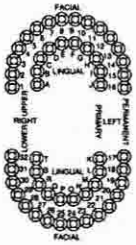
TO BE COMPLETED BY DENTIST

21. This is a request for:
☐ Request for Pre-Treatment Estimate Predetermination/Preauthorization Number _____ ☐ Statement of Services Rendered

22. Dentist's Name & Address (include zip code)	23. National Provider Identifier	24. Dentist License No.	25. Telephone Number ( )
	26. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.		
	27. First Visit Date Current Series	28. Place of Treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other	29. Radiographs or models enclosed? ☐ No ☐ Yes How many?

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

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



37. 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

38. 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 _____

39. National Provider Identification

Total charge $ _____
Amount paid $ _____
Balance due $ _____