



Cox Dental Plan Dental Benefits Request

Instructions: *Incomplete forms will delay payment.* Complete all sections. To have benefits paid directly to the dentist, sign under "Assignment." If charges are only for examination, cleaning or X-rays, you may submit itemized bills instead of having the dentist complete the provider statement. The bills must include (1) the patient's name; (2) the relationship to the employee (3) date of service (4) type of service rendered and (5) 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 (see your *Flex Healthcare Summary Plan Description* for more details). 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 that plan and the explanation of benefits you received from that plan.

Employer Name: COX ENTERPRISES, INC.		Policy/Group Number: 779409
Employee name:		Employee's ID Number*:
Birthdate (MM/DD/YYYY)		
Address, including zip code: (<input type="checkbox"/> Address is new)		Daytime telephone:
		<input type="checkbox"/> Active <input type="checkbox"/> Retired Retirement date:
PATIENT INFORMATION		
Patient name:		Patient's ID Number*:
Birthdate (MM/DD/YYYY)		
Address (if different from employee)		Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
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 Retirement date:
Employer name/address:		
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 Name		Member's ID Number*
Birthdate (MM, DD, YYYY)		
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:		
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>		
Patient's or authorized person's signature _____		Date _____
ASSIGNMENT		
I authorize payment of dental benefits to the dentist or supplier of service.		
Patient's or authorized person's signature _____		Date _____
<p>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 the claim was provided by the applicant. 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, may be subject to fines, confinement in state prison and may be liable for 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. 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.</p>		

* For ID Number, please enter the Aetna member ID number listed on the indicated person's dental ID card.

Send the completed benefits request and the bills to: Aetna Claim Office, PO Box 14079, Lexington, KY 40512.
Claim questions? Call toll free 1-888-553-3449.

