



Dental Benefits Request

RAILROAD EMPLOYEES
NATIONAL DENTAL PLAN GP-12000

How To Request Benefits

Employee Instructions

Complete **Items 1 - 18A** in the **PATIENT INFORMATION** section of this form and sign your name. If you wish your benefits paid directly to your dentist, also sign **Item 18B**, the payment authorization.

Ask the dentist to complete **Items 19 - 34** in the **DENTIST INFORMATION** section. If charges are only for examinations, cleanings or X-rays, itemized bills may be submitted instead of the dentist's portion of the form. The itemized bill must include:

- patient's name
- date of service
- condition being treated
- relationship to employee
- type of service rendered
- dentist's or supplier's taxpayer identifying number

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

Please be sure you have provided your **SOCIAL SECURITY NUMBER (Item 7)**, your **EMPLOYEE NUMBER (Item 14)** if you have one, and the **NAME OF THE UNION (Item 13)** that represents you.

You or your dentist should submit the completed attending dentist's statement to:

Aetna U.S. Healthcare
P.O. Box 14091
Lexington, KY 40512-4091
1-877-277-3368

IF YOU ANTICIPATE DENTAL WORK IN EXCESS OF **\$300**, SUBMIT A REQUEST FOR A PRE-TREATMENT ESTIMATE OF BENEFITS. ACTUAL PAYMENT MAY DIFFER FROM THE ESTIMATE. SEE BOOKLET FOR MORE INFORMATION.

NOTE: BE SURE YOU ARE ELIGIBLE FOR DENTAL BENEFITS.

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.

California Residents: 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 a state prison and substantial civil penalties.

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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dentist Instructions

Complete **Items 19-34** on the Benefit Request Form **including tooth chart**. Indicate whether the form represents a request for a pre-treatment estimate or is a statement of services actually rendered by checking the box on the top of the form.

For a pre-treatment estimate, **LEAVE THE DATE BLANK** for those services that have not been completed. Our estimate and your X-rays will be returned to you promptly. Estimates are subject to deductibles and plan maximums and may be reduced by payments made before these services are rendered. The estimate is based on the assumption the patient will receive the services while covered and the treatment plan does not change.

Actual payment may differ from estimate.

NOTE ABOUT X-RAYS: In order to expedite payment it is suggested the **PRE-TREATMENT X-RAYS** be submitted along with the Benefit Request Form when the course of treatment includes prosthetics (including all cast and porcelain restorations), oral surgery and periodontal surgery. You will be advised if x-rays are needed for any other procedure.

BENEFIT REQUEST — DENTAL

**RAILROAD EMPLOYEES
NATIONAL DENTAL PLAN GP-12000**

CHECK ONE:

<input type="checkbox"/> DENTIST'S PRE-TREATMENT ESTIMATE	IF NOT WORKING FOR THIS RAILROAD SHOW REASON(S)	<input type="checkbox"/> DISABLED	<input type="checkbox"/> PREGNANCY	<input type="checkbox"/> DISMISSED
<input type="checkbox"/> DENTIST'S STATEMENT OF ACTUAL SERVICES		<input type="checkbox"/> RESIGNED	<input type="checkbox"/> LEAVE OF ABSENCE	
		<input type="checkbox"/> FURLOUGH	<input type="checkbox"/> SUSPENDED	<input type="checkbox"/> RETIRED EFF. DATE _____

PATIENT INFORMATION

1. PATIENT NAME (FIRST MIDDLE INITIAL LAST)			2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD STEP-CHILD		3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YR			5. IF PATIENT IS A FULL TIME STUDENT SCHOOL CITY GRADUATION DATE	
6. EMPLOYEE NAME (FIRST MIDDLE INITIAL LAST)					7. EMPLOYEE SOCIAL SECURITY NUMBER				8. EMPLOYEE'S BIRTHDATE MO. DAY YR		
9. EMPLOYEE ADDRESS IS THIS A NEW ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO					10. NAME OF RAILROAD MO. & YEAR EMPLOYED						
CITY STATE ZIP TELEPHONE NUMBER ()					11. RAILROAD DIVISION, DEPARTMENT & LOCATION (CITY & STATE)						
12. EMPLOYEE OCCUPATION					13. NAME OF UNION BY WHICH YOU ARE REPRESENTED						
14. EMPLOYEE NUMBER		15. LOCATION (LOCAL)		16. ARE OTHER FAMILY MEMBERS EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO EMPLOYEE NAME SOCIAL SECURITY NUMBER IF "YES", WHERE:				17. NAME AND ADDRESS OF EMPLOYER IN ITEM 16.			
18. DO YOU HAVE OTHER DENTAL COVERAGE COVERING YOU OR A FAMILY MEMBER? (CHECK ONE) <input type="checkbox"/> YES <input type="checkbox"/> NO											
<ul style="list-style-type: none"> IF "YES", WHO'S COVERED? <input type="checkbox"/> YOURSELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER DEPENDENT <input type="checkbox"/> IF SPOUSE OR OTHER DEPENDENT, GIVE FULL NAME BIRTHDATE IF "YES", PROVIDE THE FOLLOWING: NAME & ADDRESS OF INSURANCE COMPANY OR OTHER CARRIER PROVIDING COVERAGE POLICYHOLDER CERTIFICATE NUMBER OF OTHER COVERAGE 											
18A. 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 _____											
18B. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST FOR THE SERVICES DESCRIBED BELOW. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE _____ DATE _____											

DENTIST'S INFORMATION

19. DENTIST NAME				27. IS TREATMENT RESULT OF OCCUPATIONAL INJURY OR ILLNESS		NO	YES
20. MAILING ADDRESS IS THIS A NEW ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO				28. IS TREATMENT RESULT OF AUTO ACCIDENT?			
CITY STATE ZIP				29. OTHER ACCIDENT?			
21. 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				22. DENTIST LICENSE NUMBER		31. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
				23. DENTIST TELEPHONE NUMBER ()		(IF "NO", REASON FOR REPLACEMENT)	
24. FIRST VISIT DATE		25. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER		26. RADIOGRAPHS OR MODELS ENCLOSED		NO	YES
CURRENT SERIES						33. IS THE TREATMENT FOR ORTHODONTICS?	
						IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

IDENTIFY MISSING TEETH WITH "X"		34. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.							
		TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO. DAY YR.	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY	

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.		TOTAL FEE CHARGED	
DENTIST'S SIGNATURE _____ DATE _____		Plan Maximum	
		Payable Now	