Dental Claim Form

MERITAIN HEALTH
An Aetna Company

Complete and send to:
Meritain Health
P.O. Box 27267
Minneapolis, MN 55427-0267
Fax: 1.763.852.5057

IMPORTANT: Please have your dentist or supplier of medical services complete the reverse of this form or attach a fully itemized bill – including ADA codes.

Section 1. EMPLOYEE INFORMATION

Name (last, first, initial)		Sex	Employer Name		
Home Address			Identification Number	Birthdate	Group Number
City	State	Zip Code	Work Telephone ( )	Home Telephone ( )	

Section 2. PATIENT INFORMATION

The patient is: ☐ **The employee** (Go to section 3) ☐ **Employee's Spouse** (Complete spouse information) ☐ **Employee's Child** (Complete spouse and child information)

Spouse's Name (last, first, initial)		Sex	Child's Name (first, last, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer					
Spouse's Employer's Address					

Section 3. OTHER COVERAGE

☐ **Yes** (then complete) ☐ **No** (go to section 4)

Name of Policy Holder		Policy Holder's Birthdate	Effective Date of Coverage	
Name of Other Health Insurance Carrier or Plan	Address	City	State	Zip Code
Other Insurance Carrier's or Plan's Telephone #	Type of Coverage ☐ **Group** ☐ **Individual**	Group Number	Contract or Policy Number	
Spouse's Employer				
Spouse's Employer's Address				

Section 4. ABOUT THIS CLAIM

Was this the result of an accidental injury? ☐ **Yes** ☐ **No**

Date and time of accident:	**Describe injury, when and how it happened or nature of illness:**

Section 5. EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature: **Date:**

Section 6. ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)

I authorize payment of benefits to the dentist or supplier of services listed here.

Provider to be paid	Employee's Signature
Provider's tax ID number or Social Security Number	Date

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PHYSICIAN OR SUPPLIER STATEMENT

A

Patient Name (last, first, initial)	Birthdate
Address	

B

Dentist's Name			
Address			
City	State	Zip Code	Telephone
Provider's Tax ID Number or Social Security Number	Dentist's License Number:		

C

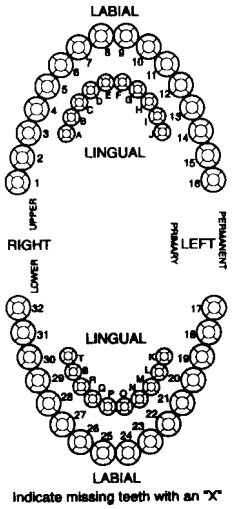
Is treatment a result of injury arising from patient's employment?	☐ Yes ☐ No	If yes, description and date:
Is treatment the result of an auto accident?	☐ Yes ☐ No	If yes, description and date:
Are any services covered by another plan?	☐ Yes ☐ No	If yes, name of other plan:
If prosthesis, is this an initial placement?	☐ Yes ☐ No	If no, reason for placement and date of previous placement:
Is treatment for orthodontics?	☐ Yes ☐ No	Date appliances placed: / Mon. of treatment remaining:

D

Is this claim for a pre-treatment?	☐ Yes ☐ No	If yes, are X-rays enclosed? ☐ Yes ☐ No

E

EXAMINATION AND TREATMENT RECORD



Tooth # or Latter	Surface	Procedure Number (ADA)	Description of Services (includes X-rays, prophylaxis, materials used, etc.)	Date of Service	Charges

F

I hereby certify that the above procedures have been completed on the date indicated.

Dentist's Signature: **Date:**

STATUS AND BENEFIT INFORMATION:
1. 866.808.2609

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