



ExxonMobil Dental Plan Claim Form

- Complete Sections 2 - 6.
 - Sign Section 7 to have benefits paid to the dentist.
 - Attach itemized bills. The bills must include:
 - patient's name, date of birth and relationship to participant
 - procedure codes
 - cost of each service or supply
 - provider's name, address and tax identification number (TIN)
- 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. 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 the other plan and the explanation of benefits you received from the other plan.
- Incomplete forms will delay payment.
- Send the completed claim form and the bills to:

Aetna
P.O. Box 14586
Lexington, KY 40512-4586
- If you have questions, call Aetna at **800-255-2386**. Overseas, call collect **210-366-2416**.

This form is for:

- Request for pre-treatment estimate Statement of services rendered

1. Employer Information	Name <p style="text-align: center;">EXXONMOBIL</p>		Policy/Group Number <p style="text-align: center;">721001</p>
2. Participant Information	Member ID Number or Social Security Number	Name	Birthdate
	<input type="checkbox"/> Employee <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor <input type="checkbox"/> COBRA		Address (include zip code)
3. Patient Information	Member ID Number or Social Security Number	Name	Birthdate
	Relationship to Participant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Address (if different from participant)
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Full-Time Student: <input type="checkbox"/> No <input type="checkbox"/> Yes		
	Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
4. Other Coverage Information	Is patient 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? <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 ID Number or Social Security Number	Insured's Name	Insured's Birthdate
5. Claim Information	Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ time _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Description of Accident		
6. Release	To all dental care providers: 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 benefit calculation information used in payment of this claim for the purpose of reviewing the experience and operation of the plan. This authorization is valid for the term of the plan 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 _____		
7. Assignment <i>Use of PPO Provider is an automatic assignment of benefits to the provider</i>	I authorize payment of dental benefits to the dentist or supplier of service. Patient's or Authorized Person's Signature _____ Date _____		
	Any person who knowingly and with intent to defraud or deceive the ExxonMobil Dental Plan files a statement of claim containing any materially false, incomplete or misleading information must repay any funds improperly received and may lose eligibility to participate in the ExxonMobil Dental Plan.		