aetna®

Coordination of Benefits Statement

PATIENT'S NAME First	Middle	Last

This patient has received the dental services described on the attached claim form. Primary coverage was provided under an Aetna managed dental plan.

The patient's out-of-pocket expenses for this course of treatment are shown below.

ADA proc code[1]	Description of Service	Date of Service Month	Day	Year	Dentist's Usual fee	Patient copay
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$

DENTIST'S NAME First	Middle	Last	
Dentist's Signature			**Office Number**

[1] Current Dental Terminology © American Dental Association. All rights reserved.