

**THE WORLD BANK GROUP**  
**CLAIM FOR DENTAL EXPENSES**

▶ If illness or injury occurred while at work, contact the Workers Compensation Insurance Representative, ext. 30807, BEFORE filling out this form.

**PART I - TO BE COMPLETED BY STAFF MEMBER OR RETIRED STAFF MEMBER (hereinafter: staff member) OR PATIENT IF COVERED SEPARATE FROM STAFF MEMBER**

1. Patient's Name (Last, First, M.I.)		2. Patient's Relationship to Staff Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child <input type="checkbox"/> Dependent Parent		3. Patient's Birthdate Month   Day   Year		4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
5. If claim is for son/daughter, was a Dependency (Tax Equivalency) Allowance payable at the time the expense was incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No. If No, please answer questions A and B below.							
A. Is he/she married? <input type="checkbox"/> Yes <input type="checkbox"/> No B. If over 18, is he/she a full time student & dependent upon you for support & maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
6. Staff Member's (or Surviving Spouse's) Name (Last, First, M.I.) IF NOT PATIENT				7. Staff Member's (or Surviving Spouse's) Birthdate IF NOT PATIENT		8. UPI No.	
9. Is patient, other than staff member, employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Employee name?				10. Name and Address of Employer in Item 9.			
11. Is patient covered by another group, student, government (e.g. Medicare) or employment related Medical Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No, If Yes, enter: Medical Plan Name _____ Group No. _____ Name & Address of Carrier _____							
<p>I authorize the release to the World Bank Group Medical Insurance Plan administrator, to the World Bank Group or their representative, any information including medical, employment and benefit information required for claim processing or plan administration. Such information shall be released directly to the World Bank Group only in circumstances where fraud or misconduct is believed to have occurred. This authorization to release information is valid for two years after the date signed. A copy of this authorization shall be as valid as the original. If the staff member is incapacitated or deceased, the Personal Representative or next of kin must sign.</p> <p>Patient's Signature (Parent/Guardian, if minor; leave blank if staff member) _____ Date _____</p> <p>I certify that the statements here and attached are complete and accurate. As the patient, I authorize the release of information as described above.</p> <p>Staff Member's Signature _____ Date _____</p>							

**PART II - TO BE COMPLETED BY ATTENDING DENTIST**

12. Dentist's Name		14. Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, enter brief description and dates							
13. Mailing Address (Street, City, State, ZIP)		15. If Prosthesis, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No. If No, reason for placement				16. Date of prior replacement			
17. Dentist's S.S.N. or T.I.N.	18. Dentist's License No.	19. Dentist's Telephone No.	20. Is treatment for Orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No	If appliance services already commenced, enter: 21. Date placed _____ 22. Months treatment remaining _____					
23. Statement of actual expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		24. Pre-treatment estimate? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Radiographs or models enclosed? <input type="checkbox"/> Yes. If yes, how many? <input type="checkbox"/> No					
26. Examination and treatment plan - list order from tooth no. 1 through tooth no. 32 (use chart shown)									
		Tooth No. or Letter	Surface (i.e., M.O. D.B.L.L.A.I)	Description of Service (including X-rays, prophylaxis, materials used, etc.)	Date Service Performed			Procedure Number	Fee
					Month	Day	Year		
<b>Total Fee Charged</b>									

27. I certify that the procedures as indicated by date have been completed Signature \_\_\_\_\_ Date \_\_\_\_\_

**Return completed form to:**  
**Aetna/World Bank MIP Claims P.O. Box 14199 Lexington, KY 40512-4199 USA OR via internal mail to MIP claims MSN MC-C3-309.**