# Dental Claim Form

**1. COMPLETE THIS FORM**
**2. ATTACH ALL BILLS**
**3. MAIL TO**

MBA Benefit Administrators
P.O. Box 57340, Murray, UT 84157-0340
(801) 268-3334

THE OPEN SOLUTION™

## PART 1 MUST BE COMPLETED BY EMPLOYEE

| | | |
|---|---|---|
| EMPLOYEE NAME | SOCIAL SECURITY NUMBER | NAME OF EMPLOYER |
| HOME ADDRESS | EMPLOYEE BIRTH DATE MONTH DAY YEAR | OCCUPATION / GROUP NUMBER |
| CITY & STATE / ZIP CODE | PHONE NO. | IS PATIENT FULL TIME STUDENT? YES NO / NAME & ADDRESS OF SCHOOL |
| PATIENT (IF OTHER THAN EMPLOYEE) NAME | SEX / PATIENT RELATIONSHIP TO EMPLOYEE / PATIENT BIRTH DATE MONTH DAY YEAR | IS PATIENT MARRIED? YES NO |
| DATE ACCIDENT OR SICKNESS BEGAN | IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN? | DID ACCIDENT HAPPEN AT WORK? YES NO |
| NATURE OF INJURY DIAGNOSIS OR CALL | | PHYSICIAN'S NAME |
| NAME OF SPOUSE | NAME AND ADDRESS OF SPOUSE'S EMPLOYER | |

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? YES NO IF YES, GIVE NAME, ADDRESS AND POLICY NUMBER OF PLAN PROVIDING BENEFITS.

NAME AND ADDRESS POLICY NO.

### IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW

**AUTHORIZATION TO PAY BENEFITS TO PROVIDERS:**
I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for servicers. But not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Covered Person Date

### PATIENT OR PARENT MUST SIGN BELOW

**AUTHORIZATION TO RELEASE INFORMATION:**
I hereby authorize any insurance company, prepayment organization, employer, hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____
Patient or Parent (If minor) Date

## PART 2 TO BE COMPLETED BY DENTIST

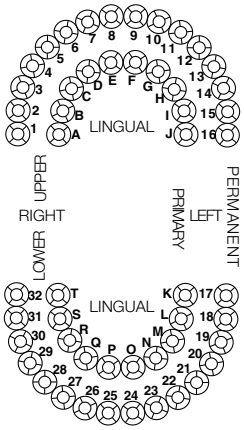
| | | | |
|---|---|---|---|
| PATIENT'S NAME | BIRTH DATE OF PATIENT | DOES PATIENT HAVE OTHER COVERAGE? YES NO | IF YES, PLEASE IDENTIFY |

| | | | | | | |
|---|---|---|---|---|---|---|
| FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT OFFICE HOSPITAL ECF OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO YES | HOW MANY? | IS TREATMENT FOR ORTHODONTICS? YES NO | IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED | MONTHS OF TREATMENT REMAINING |

| | | | |
|---|---|---|---|
| IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT | DATE OF PRIOR PLACEMENT | IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? YES NO | IF YES, ENTER BRIEF DESCRIPTION AND DATES |

**CHECK ONE:** **DENTIST'S PRETREATMENT ESTIMATE** **DENTIST'S STATEMENT OF ACTUAL SERVICES**

IDENTIFY MISSING TEETH WITH "X"




REMARKS FOR UNUSUAL SERVICES

**EXAMINATION AND TREATMENT PLAN:** LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USING CHARTING SYSTEM SHOWN

| | | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC) | DATE SERVICE PERFORMED MO. DAY YR. | PROCEDURE NUMBER | FEE | ADMINISTRATIVE USE |
|---|---|---|---|---|---|---|
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COORDINATION OF BENEFITS

Amount Charged _____
Amount C.O.B. _____
Balance Due _____

PHYSICIAN'S NAME SOC SEC.#
ADDRESS I.D. #
CITY, STATE, ZIP
DEGREE PHONE

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE - WILL BE PERFORMED HAVE BEEN PERFORMED

DENTIST'S SIGNATURE X _____

| | |
|---|---|
| TOTAL FEE CHARGED | |
| MAX. ALLOWABLE | |
| DEDUCTIBLE | |
| % OF PAYMENT | |
| PLAN PAYS | |
| PATIENT PAYS | |