MBA

THE OPEN SOLUTION™

Dental Claim Form

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

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

PART 1 MUST BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME	**ID NUMBER**	NAME OF EMPLOYER

HOME ADDRESS	EMPLOYEE DATE OF BIRTH MONTH DAY YEAR	GROUP #

CITY & STATE ZIP CODE	PHONE NO.	GENDER

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN OR INSURANCE POLICY WHICH 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

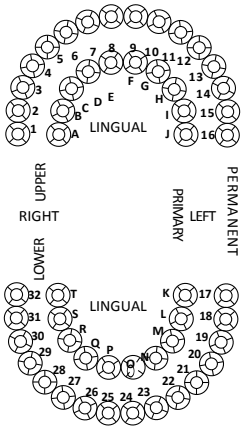
PATIENT'S NAME	PATIENT DATE OF BIRTH	GENDER	RELATIONSHIP TO EMPLOYEE

FIRST VISIT DATE (CURRENT SERIES)	PLACE OF TREATMENT OFFICE | HOSPITAL | ECF | OTHER	RADIOGRAPHS OR MODELS ENCLOSED? YES ☐ NO ☐	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

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	

CONTINENTAL