



DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION

1. STATEMENT OF ACTUAL SERVICES PREDETERMINATION REQUEST



MUTUAL HEALTH SERVICES
PO Box 5700
Cleveland, OH 44101

SUBSCRIBER INFORMATION

11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP

OTHER COVERAGE

2. OTHER DENTAL OR MEDICAL COVERAGE? NO IF NO, SKIP TO #11 YES 3. AMOUNT OF PRIMARY PAYMENT \$

4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP

12. DATE OF BIRTH 13. GENDER M F 14. SUBSCRIBER ID (SSN OR ID#)

15. PLAN/GROUP NUMBER 16. EMPLOYER NAME
City of Bowling Green

PATIENT INFORMATION

5. DATE OF BIRTH 6. GENDER M F 7. SUBSCRIBER ID (SSN OR ID#)

17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)

8. PLAN/GROUP NUMBER 9. RELATIONSHIP TO PATIENT SELF SPOUSE CHILD OTHER

18. RELATIONSHIP TO SUBSCRIBER SELF SPOUSE CHILD OTHER 19. DATE OF BIRTH 20. GENDER M F

10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME

21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS
 FULL TIME STUDENT TOTALLY & PERM DISABLED IRS DEPENDENT SPONSORED DEP

DENTAL SERVICES

	22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION	28. FEE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

30. PLACE X ON MISSING TOOTH NUMBER(S)	MISSING TEETH																PERMANENT										PRIMARY										29. TOTAL FEE CHARGED		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	T	S	R	Q	P	O	N	M	L	K			

REMARKS
31.

AUTHORIZATIONS

32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.

PATIENT/GUARDIAN SIGNATURE DATE

33. WHERE PERMITTED BY LAW, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.

SUBSCRIBER SIGNATURE DATE

ADDITIONAL CLAIM INFORMATION

34. PLACE OF TREATMENT
 DENTAL OFFICE HOSPITAL ECF OTHER

35. NUMBER OF ENCLOSURES
RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____

36. IS TREATMENT RELATED TO ORTHODONTICS? NO YES
DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____

37. TREATMENT RESULTING FROM:
 OCCUPATIONAL ILLNESS/INJURY AUTO ACCIDENT OTHER ACCIDENT

38. REPLACEMENT OF PROSTHESIS?
 YES DATE PRIOR PLACEMENT _____ NO

BILLING DENTIST/DENTAL ENTITY (#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)

39. NAME, ADDRESS, CITY, STATE, ZIP

40. NPI 41. LICENSE NUMBER 42. TIN

43. PHONE NUMBER ()

TREATING DENTIST AND LOCATION

44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO PREDETERMINE THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGEMENT.

X _____
SIGNED (TREATING DENTIST) DATE

45. NPI 46. LICENSE NUMBER 47. TIN

48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)

49. PHONE NUMBER () 50. ADDITIONAL DENTIST ID 51. SPECIALTY CODE