



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

Dental Claim Form

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

PART 1 MUST BE COMPLETED BY EMPLOYEE

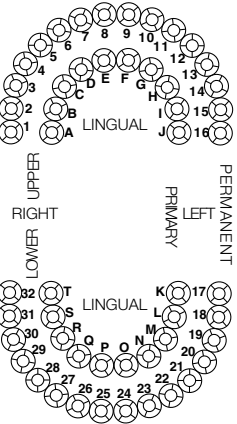
EMPLOYEE NAME		SOCIAL SECURITY NUMBER		NAME OF EMPLOYER					
HOME ADDRESS		EMPLOYEE BIRTH DATE	MONTH	DAY	YEAR	OCCUPATION	GROUP NUMBER		
CITY & STATE		PHONE NO.		IS PATIENT FULL TIME STUDENT? YES NO		NAME & ADDRESS OF SCHOOL			
PATIENT (IF OTHER THAN EMPLOYEE) NAME		SEX	PATIENT RELATIONSHIP TO EMPLOYEE		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	PATIENT OR PARENT MUST SIGN BELOW
<p>AUTHORIZATION TO PAY BENEFITS TO PROVIDERS: I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services. 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.</p> <p><input checked="" type="checkbox"/> _____ Date _____ Covered Person</p>	<p>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.</p> <p><input checked="" type="checkbox"/> _____ Date _____ Patient or Parent (If minor)</p>

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

COORDINATION OF BENEFITS Amount Charged _____ Amount C.O.B. _____ Balance Due _____	PHYSICIAN'S NAME		SOC SEC.#		TOTAL FEE CHARGED	
	ADDRESS		I.D.#		MAX. ALLOWABLE	
	CITY, STATE, ZIP		PHONE		DEDUCTIBLE	
	I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE - WILL BE PERFORMED HAVE BEEN PERFORMED				% OF PAYMENT	
DENTIST'S SIGNATURE <input checked="" type="checkbox"/>				PLAN PAYS		
				PATIENT PAYS		