[redacted]

Medical Mutual of Ohio
P.O. Box 6018
Cleveland, OH 44101-1018

MM886 R4/97 PLEASE PRINT OR TYPE SEE INSTRUCTIONS ON BACK

DENTAL

☐ ACTUAL SERVICES ☐ PRE-TREATMENT ESTIMATE
☐ ENCOUNTERED CLAIM

SUBSCRIBER COMPLETES THIS SECTION

1. SUBSCRIBER'S LAST NAME	FIRST	M.I.	2. EMPLOYER/GROUP NO.	3. CERTIFICATE NO.	4. PAGE ____ OF ____
(ACCURACY IMPORTANT)				(ACCURACY IMPORTANT)	

5. SUBSCRIBER'S ADDRESS	STREET NO.	STREET NAME	CITY	STATE	ZIP CODE

6. PATIENT'S LAST NAME	FIRST	M.I.	7. SEX	8. PATIENT'S BIRTHDAY MO. DAY YR.	9. RELATIONSHIP OF PATIENT TO SUBSCRIBER
					1. ☐ SELF 2. ☐ SPOUSE 3. ☐ DEPENDENT CHILD 4. ☐ FULL TIME STUDENT 5. ☐ HANDICAPPED 6. ☐ DEPENDENT CHILD AGE 18 AND OVER

10. IF PATIENT IS COVERED BY ANOTHER DENTAL PLAN, PLEASE ADVISE:

11. POLICY HOLDER OF OTHER INSURANCE/POLICY NUMBER

12. OTHER INSURANCE COMPANY NAME

13. POLICYHOLDER'S EMPLOYER/POLICY'S EFFECTIVE DATE

14. POLICYHOLDER'S DATE OF BIRTH

15. ACCIDENT? YES ☐ NO. ☐

16. DATE OF ACCIDENT MO. DAY YEAR

17. IF ACCIDENT, DID IT OCCUR ON THE JOB? YES ☐ NO. ☐

18. IF ACCIDENT, WAS ANOTHER PERSON INVOLVED? YES ☐ NO ☐

19. I AUTHORIZE RELEASE OF ANY INFORMATION PERTAINING TO THIS CLAIM TO MEDICAL MUTUAL OF OHIO OR A REVIEW AGENCY WITH WHICH IT HAS CONTRACTED SOLELY FOR THE PURPOSE OF DETERMINING REIMBURSEMENT.

X
Signature of certificate holder or spouse — Date

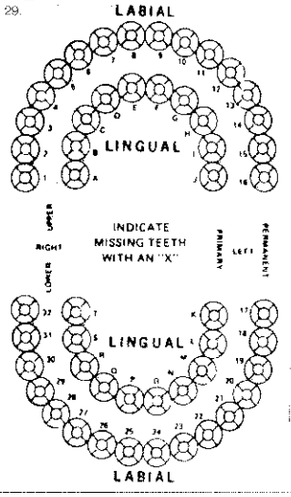
20. I AUTHORIZE MEDICAL MUTUAL OF OHIO, *AT ITS OPTION*, TO ISSUE PAYMENT TO THE PROVIDER DESCRIBED ON THIS CLAIM.

X
Signature of certificate holder or spouse — Date

DENTIST COMPLETES THIS SECTION

21. ARE X-RAYS ENCLOSED? YES ☐ NO ☐
IF YES INDICATE NUMBER ——

29.



EXAMINATION & TREATMENT — LIST IN ORDER TOOTH #1 THROUGH TOOTH #32

22. LINE NO.	23. TOOTH NO. OR LETTER	24. SURFACES	25. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	26. DATE SERV.COMP. MO. DAY YR.	27. FEE FOR EACH SERVICE COMPLETED	28. PROCEDURE CODE NO.
01						
02						
03						
04						
05						
06						
07						
08						
09						
10						

30. PLACE OF SERVICE
1 ☐ IN-PATIENT 3. ☐ OFFICE
2 ☐ OUT-PATIENT 4. ☐ HOME

31. WERE SERVICES INDICATED RENDERED FOR ORTHODONTICS PURPOSES? YES ☐ NO ☐

33. PAGE TOTAL ➤ FEE

32. IF PROSTHESIS/CROWN IS THIS AN INITIAL PLACEMENT? YES ☐ NO ☐ IF NO, DATE OF PRIOR PLACEMENT AND REASON TO REPLACE

34. GRAND TOTAL ➤ FEE

IF CLAIM IS FOR PERIO SERVICES, X-RAY AND PERIO CHARTING ARE REQUIRED.

37. PROVIDER NAME and ADDRESS

35. ADDITIONAL REMARKS FOR UNUSUAL SERVICES OR NARRATIVE FOR PREDETERMINATION

36. I CERTIFY THAT THE ABOVE SERVICES ARE SUBMITTED FOR PREDETERMINATION OF BENEFITS, OR HAVE BEEN PERSONALLY PERFORMED BY ME, OR ARE APPROVED DENTAL HYGIENIST SERVICES SUPERVISED BY ME.

38. TAX IDENTIFICATION NUMBER AND SUFFIX

39. OFFICE PHONE NO.

SIGNATURE — DATE

[illegible]

[illegible]

COMMONLY USED PROCEDURE CODE

PROCEDURE CODE	DESCRIPTION OF SERVICE	PROCEDURE CODE	DESCRIPTION OF SERVICE	PROCEDURE CODE	DESCRIPTION OF SERVICE
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[illegible]