

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

1886 R4/97 PLEASE PRINT	OR TYPE SE	E INSTRUCT	IONS ON BA	DENTAL	ACTUAL SE	RVICES L F	RE-TREATM		
1. SUBSCRIBER'S LAST NAME	F	IRST	SUB M.I.	SCRIBER COMPLETES THIS SE 2. EMPLOYER/GROUP NO.	CTION 3. CERTIFICATE NO.			4.	
								PAGE	
(ACC	URACY IMPORTANT)				(ACCURA	CY IMPORTANT)		OF	
5. SUBSCRIBER'S STREET NO. STREET NAME				CITY	STATE ZIP CODE			NDE	
ADDRESS	THEET NO.	51	HEET NAME	CIT	SIAIE		ZIP UL)DE	
6. PATIENT'S LAST NAME	FIRST		M,I. 7. SEX	8. PATIENT'S 9. RELATIONSHIP OF PATIENT	TO SUBSCRIBER DEP	ENDENT CHILD AGE 1	3 AND OVER		
6. PATIENT'S LAST NAME FIRST M.I. 7. SEX 10. IF PATIENT IS COVERED BY ANOTHER DENTAL PLAN, PLEASE ADVISE:			BIRTHOAY MO. DAY YR. 1. SELF 3. DEPENDENT CHILD 4. FULL TIME STUDENT 5. HANDICAPPED						
				2. SPOUSE	6.	DEPENDENT CHILI	AGE 18 AND OVER		
10. IF PATIENT IS COVERED BY ANOTHER DEN	TAI. PLAN, PLEASE AS	VISE:		15. ACCIDENT? 16. DATE OF ACC		F ACCIDENT, DIÐ IT OF THE JOB?	CUR 18. IF ACCID ER PERSON	ENT, WAS ANOTH INVOLVED?	
11. POLICY HOLDER OF OTHER INSURANCE/PO	DLICY NUMBER			YES NO.I		YES NO.	YES	NO I	
12. OTHER INSURANCE COMPANY NAME				19. LAUTHORIZE RELEASE OF ANY INFORMATION PERTAINING SOLELY FOR THE PURPOSE OF DETERMINING REMBURSEMEN		OHIO OR A REVIEW AGENC	Y WATH WHICH IT HAS GOI	NIHACTED .	
13. POLICYHOLDER'S EMPLOYER/POLICY'S EFI	FECTIVE DATE			X Signature of certificate holder or spouse Date					
14. POLICYHOLDER'S DATE OF BIRTH	-			20. I AUTHÓRIZE MEDICAL MUTUAL OF OHIO, <i>AT.ITS</i>	OPTION, TO ISSUE PAYMENT TO	THE PROVIDER DESC	RIBED ON THIS CLAIR	d.	
			DEN	Signature of certificate holder or spouse TIST COMPLETES THIS SECT	FIONI		Date		
21. ARE X-RAYS ENCLOSED? YES NO	··			EXAMINATION & TREATMENT — LIST IN ORDER TO					
IF YES INDICATE NUMBER ——	! 22. LINE NO.	23. TOOTH NO. OR LETTER	24. SURFACES	25. DESCRIPTION OF SE (INCLUDING X-RAYS, PROPHYLAXIS, M.		26. DATE SERV.COMP. 500. DAY YR	27. FEE FOR EACH SERVICE COMPLETED	28. PROCEDURE CODE NO.	
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LABIAL 30. PLACE OF SERVICE	10								
1 N-PATIENT 3. OFFICE 2 OUT-PATIENT 4. HOME	31.	EDVICES INITIOATE	ED RENDERED FOR	33. PAGE TOTAL ➤					
OR LE PROPERIE CIC (CROWN)	Name of the second seco	vo [FEE 34. GRAND						
SC. IF PROSINESSO-GROWN IS THIS AN INITIAL PLACEMENT? IF NO, DATE OF PRIOR PLACEMENT AND REASON TO REPLACE									
IF CLAIM IS FOR PERIO SERVICES, X-R	AY AND PERIO CI	HARTING ARE F	EQUIRED.	35. ADDITIONAL REMARKS FOR	UNUSUAL SERVICES OR NARRATI	VE FOR PREDETERMI	NATION		
STATE OF THE PROPERTY AND APPLICANT									
				36. I CERTIFY THAT THE A	BOVE SERVICES ARE SUBMI	TTED FOR PREDET	'ERMINATION		
				OF BENEFITS, OR HAV	E BEEN PERSONALLY PERFO ERVICES SUPERVISED BY ME	PAMED BY ME, OR			
38. TAX IDENTIFICATION NUMBER AND SUFFIX	39. (DEFICE PHONE NO	i.	SIGNATURE				DATE	

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