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CLAIMS OFFICE USE ONLY

DENTAL CLAIM FORM

CHECK ONE: DENTIST'S PRE-TREATMENT ESTIMATE
 DENTIST'S STATEMENT OF ACTUAL SERVICES

| | | | | | | | | | |
|--|---|--|---|--|--|--|---|-------------------|--------------------|
| INSURED AND PATIENT SECTION | INSURED NAME | | DESERET MUTUAL ID NO. | | EMPLOYER NAME | | INSURED BIRTH DATE | | |
| | STREET ADDRESS | | | CITY | STATE | ZIP | HOME PHONE NUMBER | WORK PHONE NUMBER | |
| | SPOUSE NAME | | | SPOUSE SOC. SEC. NUMBER | | SPOUSE EMPLOYER – If not employed, check here <input type="checkbox"/> | | SPOUSE BIRTH DATE | |
| | PATIENT NAME | | PATIENT RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/> SPOUSE | | IF CHILD, IS HE/SHE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE? | | IF CHILD, IS HE/SHE MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | PATIENT BIRTH DATE |
| | IS TREATMENT THE RESULT OF AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | DATE OF ACCIDENT | WAS ACCIDENT RELATED TO: A. PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | WHERE DID THE ACCIDENT HAPPEN? | | |
| | HOW DID THE ACCIDENT HAPPEN? | | | | | | | | |
| | IS THERE SOMEONE ELSE (A THIRD PARTY, ETC.) WHO MAY BE LIABLE TO PAY THE CLAIMED DENTAL EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS. | | | | | | | | |
| | IS THE PATIENT COVERED BY ANY OTHER GROUP INSURANCE, HEALTH MAINTENANCE ORGANIZATION, OR GOVERNMENT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE STATE: | | | | | | | | |
| | A. THE INSURED'S NAME: _____ | | | | | | | | |
| | B. THE INSURED'S SOCIAL SECURITY NUMBER: _____ | | | | | | | | |
| C. THE NAME OF THE GROUP POLICY HOLDER AND CONTRACT NUMBER(S): _____ | | | | | | | | | |
| D. THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE INSURANCE COMPANY OR OTHER PROVIDER OF BENEFITS: _____ | | | | | | | | | |
| I CERTIFY THE ABOVE INFORMATION IS CORRECT AND COMPLETE AND AUTHORIZE DESERET MUTUAL AND/OR HEALTH CARE PROVIDERS TO SECURE OR RELEASE INFORMATION RELATING TO THIS CLAIM. X _____ DATE _____ | | | | I AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST NAMED BELOW FOR THE FOLLOWING SERVICES DESCRIBED. X _____ DATE _____ | | | | | |

| DENTIST NAME | | SPECIALTY | | SOCIAL SECURITY OR TAX I.D. NUMBER | | LICENSE NUMBER | | TELEPHONE NUMBER | | | |
|---|---|---|---|--|-------------------------|--|---|--------------------------------|--------------------|------------------------|-----|
| MAILING ADDRESS (INCLUDING CITY, STATE, AND ZIP) | | | | | | | | | | | |
| First Visit Date Current Series | Radiographs or models enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No | How Many? | If prosthesis, is this the initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No | If no, state the reason for replacement: | Date of prior placement | Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No | If services have already commenced, enter the date appliances were placed | Months of treatment remaining? | | | |
| IDENTIFY MISSING TEETH WITH "X" | | EXAMINATION AND TREATMENT PLAN – List in order from tooth 1 through 32 – Use charting system shown. | | | | | | | | CLAIMS OFFICE USE ONLY | |
| | | Tooth # of Letter | Surface | DESCRIPTION OF SERVICE (Including x-rays, prophylaxis, materials used, etc.) | | | DATE SERVICE PERFORMED Mo. Day Year | | ADA PROCEDURE CODE | | FEE |
| | | 1 | | | | | | | | | |
| | | 2 | | | | | | | | | |
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| | | 12 | | | | | | | | | |
| | | 13 | | | | | | | | | |
| | | 14 | | | | | | | | | |
| 15 | | | | | | | | | | | |
| I CERTIFY THE PROCEDURES, AS INDICATED BY DATE, HAVE BEEN COMPLETED, AND THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT. | | | | | | | | TOTAL FEE CHARGED | | | |
| SIGNED (DENTIST) _____ DATE _____ | | | | | | | | | | | |

HELP US PROCESS YOUR CLAIM

To file a Dental Claim form, follow these steps:

1. Complete the information requested in the Insured and Patient section of the claim form and sign it.
2. Take the claim form with you when you visit the dentist. Each patient will need his/her own claim form.
3. Have the dentist complete the rest of the form for preauthorization or for payment.
4. Periapical x-rays must be submitted with the claim form for the following services:
 - Root canal therapy
 - Crowns
 - Bridgework
 - Extraction of impacted teeth
 - Space maintainers
 - Gold inlays and onlays

COORDINATION OF BENEFITS

When you or your dependents are covered under more than one group dental plan, benefits may be coordinated, with possible payment of benefits from both sources. (Your Employee Handbook explains Coordination of Benefits in detail.) Remember your claim must first be processed by the primary insurance carrier before the secondary insurance carrier can make payment.

Claims **must be submitted within 15 months** from the date the service was received. Claims received after that date will not be eligible for benefits.

Send the claim form and x-rays (when applicable) to:

**Deseret Mutual
P.O. Box 45530
Salt Lake City, Utah 84145**

When the claim has been processed, you will receive an Explanation of Benefits from Deseret Mutual, verifying payment and explaining how your claim has been handled. If you have any questions, please contact Customer Service at the address above or call:

Salt Lake City, Utah Area 1-801-578-5600
Toll Free 1-800-777-3622

NOTE: Be sure all of the requested information is filled in and submitted. Failure to do so may delay the processing of your claim.