



150 Social Hall Avenue, Suite 170  
 P.O. Box 45530 • Salt Lake City, Utah 84145  
 Telephone: 801-578-5600 • Toll free: 800-777-3622  
 Fax: 801-578-5901 • Website: www.dmba.com

## MEDICAL & DENTAL CLAIM FORM

### A. PARTICIPANT INFORMATION

Participant name: \_\_\_\_\_ Birth date (mm/dd/yy): \_\_\_\_\_

DMBA ID number: \_\_\_\_\_

Address: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Work telephone: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Birth date (mm/dd/yy): \_\_\_\_\_

Patient's relationship to participant:  Self  Spouse  Child  Other \_\_\_\_\_

### B. PROVIDER INFORMATION

Provider name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Tax Identification Number (TIN): \_\_\_\_\_ National Provider Identifier (NPI): \_\_\_\_\_

### C. PAYMENT METHOD

Who do you wish to receive payment?  Service provider  Participant

I certify this information is true and complete. I authorize DMBA, healthcare providers, and/or persons or entities retained by DMBA for the purpose of auditing claims to secure or release information relating to this claim. I understand, agree, and consent that this authorization shall remain in effect indefinitely.

Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_\_

### D. ACCIDENT INFORMATION

Is treatment the result of an accident?  Yes (accident date: \_\_\_\_\_ )  No (proceed to section E)

Describe location and condition of injury: \_\_\_\_\_

How did the accident happen? \_\_\_\_\_

Where did the accident happen? \_\_\_\_\_

Was the accident related in any way to: Patient's employment?  Yes  No Auto accident?  Yes  No

Is there someone else who may be liable to pay for these expenses (a third party, etc.)?  Yes  No

If you answer "yes" to any of the questions above, please complete the [Accident Information Request Form](#) in the *Forms Library* on www.dmba.com.

**E. OTHER INSURANCE INFORMATION**

Is the patient covered by any other group insurance, health maintenance organization (HMO), or government plan (including Medicare)?  Yes (complete the following information)  No

Insurance company name: \_\_\_\_\_

Policy holder's name: \_\_\_\_\_

Policy number: \_\_\_\_\_

**HELP US PROCESS YOUR CLAIM**

- 1. You must include a properly completed and signed claim form each time you submit a bill.
- 2. Attach an itemized bill from the service provider that includes the following:

**Medical Services**

- Date of service
- Diagnosis codes
- Procedure codes
- Place of service
- Amount charged for each service
- Provider name, address, & phone number
- Provider TIN
- Provider NPI

**Dental Services**

- Date of service
- Procedure codes
- Tooth numbers and surfaces
- Place of service
- Amount charged for each service
- Provider name, address, and phone number
- Provider TIN
- Provider NPI

- 3. Claims **must be submitted within 12 months** from the date the service was rendered. Claims received after this date will not be eligible for benefits.
- 4. Send the claim form and itemized bills to:

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

When the claim has been processed, you will receive an *Explanation of Benefits* (EOB) from DMBA explaining how your claim has been handled. If you have any questions, please contact DMBA:

Salt Lake City area. . . . . 801-578-5600  
Toll free . . . . . 800-777-3622

**NOTE:** Be sure to complete **all** of the requested information. If you don't, processing of your claim may be delayed.