

ATTENDING DENTIST'S STATEMENT

SEND
CLAIMS
DIRECTLY
TO:

MedBen
P.O. Box 1129 • 1975 Tamarack Road • Newark, Ohio 43058-1129
(740) 522-8425 • Toll-Free (800) 423-3151

PART I — TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. PATIENT BIRTH DATE Mo. Day Year		5. IF FULL TIME STUDENT School City Term Credit Hrs.		
6. EMPLOYEE / MEMBER / SUBSCRIBER NAME (FIRST, MIDDLE, LAST)					7. EMPLOYEE SOCIAL SECURITY NO. OR ID NO.			EMPLOYEE BIRTH DATE Mo. Day Year		
8. EMPLOYEE MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE					11. COMPANY (EMPLOYER) NAME AND ADDRESS AND/OR DIVISION AND PLANT LOCATION					
9. EMPLOYEE MAILING ADDRESS (Check if Change of Address <input type="checkbox"/>)			10. GROUP/ACCOUNT NO.							
CITY, STATE, ZIP			HOME PHONE NO.							
12. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Family Member's Name				SOCIAL SECURITY NO.		13. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 11			SPOUSE BIRTH DATE Mo. Day Year	
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate		DENTAL PLAN NAME		UNION LOCAL		GROUP ACCOUNT NO.		NAME AND ADDRESS OF CARRIER		
IS PATIENT A MINOR IN THE CUSTODY OF A PERSON OTHER THAN THE EMPLOYEE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name and address of the person with legal custody of the patient.										
RELEASE OF INFORMATION - PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits, and (4) any employer to provide Medical Benefits Mutual Life Insurance Co., its subsidiaries, or their legal representatives any information in their possession which is relevant to this claim or to the specific treatment or condition(s) for which the patient is being treated. This information will be used to determine the benefits payable and will be utilized by employees and agents of Medical Benefits Mutual Life Insurance Co. or its subsidiaries with responsibility for review and payment of claims. I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, stop loss carriers and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health status of, and health care services provided to, the patient. This authorization is effective on the date signed and shall remain in effect for the term of my coverage under the plan of benefits administered by Medical Benefits Mutual Life Insurance Co. or its subsidiaries. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original.										
PATIENT OR AUTHORIZED PERSON'S SIGNATURE - DATE										
AUTHORIZATION TO PAY BENEFITS TO DENTIST — I hereby authorize payment directly to the below named Dentist of the dental benefits otherwise payable to me.										
PATIENT OR AUTHORIZED PERSON'S SIGNATURE - DATE										

WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER OR HEALTH BENEFIT PLAN, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE OR HEALTH CARE FRAUD UNDER STATE AND/OR FEDERAL LAW.

PART II — TO BE COMPLETED BY ATTENDING DENTIST

15. DENTIST NAME			23. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES							
16. MAILING ADDRESS			24. IS TREATMENT RESULT OF AUTO ACCIDENT?											
CITY, STATE, ZIP			25. OTHER ACCIDENT?											
17. DENTIST SOC. SEC. OR T.I.N.			18. DENTIST LICENSE NO.		19. DENTIST PHONE NO.		26. ARE ANY SERVICES COVERED BY ANOTHER PLAN?		IF YES, NAME OF OTHER PLAN:					
20. FIRST VISIT DATE CURRENT SERIES		21. PLACE OF TREATMENT OFFICE HOSP ECF OTHER		22. RADIOGRAPHS OR MODELS ENCLOSED?		HOW MANY?		27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		(IF NO, REASON FOR REPLACEMENT)				
				<input type="checkbox"/> NO <input type="checkbox"/> YES				28. DATE OF PRIOR PLACEMENT		29. IS TREATMENT FOR ORTHODONTICS?				
								IF SERVICES ALREADY COMMENCED, ENTER		DATE APPLIANCES PLACED				
										MOS. TREATMENT REMAINING				
CHECK ONE <input type="checkbox"/> For Actual Services <input type="checkbox"/> For Pre-Treatment Estimate			30. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 — USE CHARTING SYSTEM SHOWN											
<p>Indicate missing teeth with an "X"</p>			TOOTH # OR LETTER	SURFACE (i.e., M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED MO. DAY YEAR	PROCEDURE NUMBER	FEE						
31. Remarks for unusual services														
I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.					SIGNED (DENTIST)		DATE		TOTAL FEE CHARGED					

INSTRUCTIONS FOR FILING YOUR MEDBEN CLAIM

Please take time to familiarize yourself with these instructions. Proper completion of the form by you will prevent unnecessary delays in processing your claim. All incomplete claim forms will be returned.

1. Complete the top section indicated on the left margin as Part I.
2. Please submit a separate claim form for each patient.
3. Keep a copy of the bills for your record. This can prevent you from inadvertently filing duplicate claims.
4. If you are also covered by another insurer, Blue Cross/Blue Shield plan, HMO, Medicare, or other governmental agency, please be sure to attach a copy of that Company's Explanation of Benefits to this claim. Check the Explanation of Benefits form to be sure that it is for the same date(s) of service, provider, and charges that you are submitting on this claim.

INSTRUCTIONS FOR DIRECT MAILING: Turn statement over to the front side, fold twice like a letter (top folds down, bottom folds up). The mailing address should appear on one side and a blank panel on the other side. Tape the form closed at bottom center of mailing address side, affix proper postage and mail. If sending more than one statement, use an envelope.

MedBen
P.O. Box 1129, 1975 Tamarack Road
Newark, Ohio 43058-1129

Put Stamp Here.
The Post Office
will not deliver
mail without
proper postage.
