

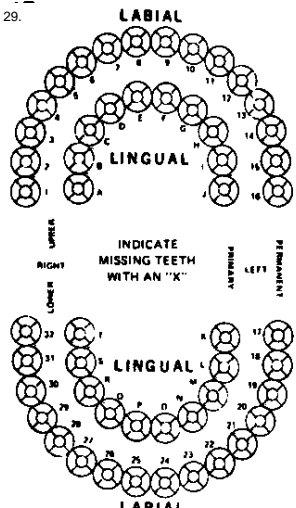
ACTUAL SERVICES     PRE-TREATMENT ESTIMATE  
 ENCOUNTERED CLAIM

Z3226 R6/00    PLEASE PRINT OR TYPE    SEE INSTRUCTIONS ON BACK

## DENTAL

SUBSCRIBER COMPLETES THIS SECTION											
1. SUBSCRIBER'S LAST NAME <small>(ACCURACY IMPORTANT)</small>			FIRST	M.I.	2. EMPLOYER/GROUP NO.			3. CERTIFICATE NO. <small>(ACCURACY IMPORTANT)</small>			
5. SUBSCRIBER'S ADDRESS STREET NO.                      STREET NAME                      CITY                      STATE                      ZIP CODE											
6. PATIENT'S LAST NAME <small>(ACCURACY IMPORTANT)</small>			FIRST	M.I.	7. SEX	8. PATIENT'S BIRTHDAY MO.   DAY   YR.		9. RELATIONSHIP OF PATIENT TO SUBSCRIBER 1. <input type="checkbox"/> SELF                      3. <input type="checkbox"/> DEPENDENT CHILD 2. <input type="checkbox"/> SPOUSE                      6. <input type="checkbox"/> DEPENDENT CHILD AGE 18 AND OVER		DEPENDENT CHILD AGE 19 AND OVER 4. <input type="checkbox"/> FULL TIME STUDENT                      5. <input type="checkbox"/> HANDICAPPED	
10. IF PATIENT IS COVERED BY ANOTHER DENTAL PLAN, PLEASE ADVISE:					15. ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		16. DATE OF ACCIDENT MO.   DAY   YEAR		17. IF ACCIDENT, DID IT OCCUR ON THE JOB? YES <input type="checkbox"/> NO <input type="checkbox"/>		
11. POLICY HOLDER OF OTHER INSURANCE/POLICY NUMBER					18. IF ACCIDENT, WAS ANOTHER PERSON INVOLVED? YES <input type="checkbox"/> NO <input type="checkbox"/>		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. <input checked="" type="checkbox"/> Signature of certificate holder or spouse                      Date				
12. OTHER INSURANCE COMPANY NAME					20. I AUTHORIZE MEDICAL MUTUAL OF OHIO, <i>AT ITS OPTION</i> , TO ISSUE PAYMENT TO THE PROVIDER DESCRIBED ON THIS CLAIM. <input checked="" type="checkbox"/> Signature of certificate holder or spouse                      Date						
13. POLICYHOLDER'S EMPLOYER/POLICY'S EFFECTIVE DATE											
14. POLICYHOLDER'S DATE OF BIRTH											

SUBSCRIBER COMPLETES THIS SECTION

DENTIST COMPLETES THIS SECTION										
EXAMINATION & TREATMENT — LIST IN ORDER TOOTH #1 THROUGH TOOTH #32										
21. ARE X-RAYS ENCLOSED? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES INDICATE NUMBER _____		22. LINE NO.	23. TOOTH NO. OR LETTER	24. SURFACES	25. DESCRIPTION OF SERVICE <small>(INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)</small>	26. DATE SERV. COMP. MO. DAY YR.	27. FEE FOR EACH SERVICE COMPLETED	28. PROCEDURE CODE NO.		
 <p align="center">INDICATE MISSING TEETH WITH AN "X"</p>		29. 01								
		02								
		03								
		04								
		05								
		06								
		07								
		08								
		09								
		10								
30. PLACE OF SERVICE 1 <input type="checkbox"/> IN-PATIENT    3 <input type="checkbox"/> OFFICE 2 <input type="checkbox"/> OUT-PATIENT    4 <input type="checkbox"/> HOME		31. WERE SERVICES INDICATED RENDERED FOR ORTHODONTICS PURPOSES? YES <input type="checkbox"/> NO <input type="checkbox"/>					33. DATE TOTAL FEE			
32. IF PROSTHESIS/CROWN IS THIS AN INITIAL PLACEMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 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.					35. ADDITIONAL REMARKS FOR UNUSUAL SERVICES OR NARRATIVE FOR PREDETERMINATION					
37. PROVIDER NAME and ADDRESS					36. <b>WARNING:</b> Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.  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 _____					

DENTIST COMPLETES THIS SECTION

**SUBSCRIBER/PATIENT INSTRUCTIONS**

USE THE CURRENT MEDICAL MUTUAL OF OHIO IDENTIFICATION CARD TO COMPLETE BLOCKS 1 THROUGH 3. BLOCKS 5 THROUGH 9 REQUEST NECESSARY ADDITIONAL INFORMATION IDENTIFYING THE SUBSCRIBER AND THE PATIENT. BLOCKS 10 THROUGH 14 DESCRIBE ANY OTHER DENTAL COVERAGE FOR THE PATIENT. BLOCKS 15 THROUGH 18 ESTABLISH REQUIRED FACTS FOR ACCIDENT RELATED DENTAL TREATMENT BLOCK 19 IS SIGNED BY THE SUBSCRIBER/SPOUSE TO AUTHORIZE RELEASE OF INFORMATION. BLOCK 20 IS SIGNED BY THE SUBSCRIBER OR SPOUSE TO AUTHORIZE PAYMENT TO THE DENTIST. WITHOUT THIS SIGNATURE, PAYMENT WILL BE MADE TO THE SUBSCRIBER.

**DENTAL OFFICE INSTRUCTIONS**

USE BLOCKS 4 TO NUMBER AND RECORD THE TOTAL PAGES SUBMITTED. INFORMATION REGARDING ACCOMPANYING X-RAYS IS REQUESTED IN BLOCK 21. LIST EACH SPECIFIC SERVICE ON A SEPARATE LINE COMPLETING BLOCKS 23 THROUGH 28 USE THE CHART IN BLOCK 29 TO IDENTIFY MISSING TEETH. BLOCKS 30 THROUGH 32 ARE REQUIRED TO DEFINE THE PLACE AND TYPE OF SERVICE. TOTAL FEES FOR EACH PAGE SUBMITTED, AND THE OVERALL TOTAL, ARE REQUESTED IN BLOCKS 33 AND 34. UNUSUAL SERVICES MAY BE DESCRIBED IN BLOCK 35 PROVIDER IDENTIFICATION AND CERTIFICATION OF SERVICES MUST BE FURNISHED IN BLOCKS 36 THROUGH 39.

**COMMONLY USED PROCEDURE CODE**

PROCEDURE CODE	DESCRIPTION OF SERVICE	PROCEDURE CODE	DESCRIPTION OF SERVICE	PROCEDURE CODE	DESCRIPTION OF SERVICE
<b><u>DIAGNOSTIC AND PREVENTIVE</u></b>		<b><u>OTHER RESTORATIONS AND RECEMENTING</u></b>		<b><u>PROSTHODONTICS - REMOVABLE (Cont'd)</u></b>	
0110	Initial Exam	2910	Recement Inlays	5730	Complete Denture Reline - Office
0120	Periodic Exam	2920	Recement Crown	5740	Partial Denture Reline - Office
0210	Intra-Oral Complete Series (Including Bitewings) (Limited to once every three years)	2940	Sedative Filing	5750	Complete Denture Reline - Laboratory
0220	Intra-Oral First Film	6930	Recement Bridge	5760	Partial Denture Reline - Laboratory
0230	Intra-Oral Each Additional Film	<b><u>ENDODONTICS</u></b>		5850	Tissue Conditioning
0270	Bite-Wing X-Ray	3110	Pulp Cap Direct	<b><u>DENTURE REPAIRS</u></b>	
0272	Bite-Wing Films, Two	3120	Pulp Cap Indirect	5610	Repair Complete or Partial Denture - No Teeth Involved
0273	Bite-Wing Films, Three	3220	Vital Pulpotomy	5610	Repair Complete or Partial Denture - Replace One Tooth
0274	Bite-Wing Films, Four	3310	Root Canal Therapy - One Canal	5630	Each Additional Tooth
0330	Panoramic - Maxilla and Mandible Film	3320	Root Canal Therapy - Two Canals	5640	Replace Broken Tooth - No Other Repairs
0470	Diagnostic Casts	3330	Root Canal Therapy - Three Canals	5650	Add Tooth to Partial to Replace Extracted Tooth (Not Involving Clasp or Abutment)
1110	Prophylaxis - Adult	3340	Root Canal Therapy - Four Canals	5660	Add Tooth to Partial to Replace Extracted Tooth (Involving Clasp or Abutment)
1120	Prophylaxis - Child (Under age 12)	3410	Apicoectomy (Separate Procedure)	5670	Reattaching Damaged Clasp on Denture
<b><u>RESTORATIVE</u></b> (Multiple restorations in one surface will be considered a single restoration)		3420	Apicoectomy (With Root Canal)	5680	Replacing Broken Clasp with New Clasp
<b><u>PRIMARY TEETH</u></b>		<b><u>PERIODONTICS</u></b>		<b><u>PROSTHODONTICS - FIXED ABUTMENTS</u></b>	
2110	Amalgam - One Surface	4210	Gingivectomy or Gingivoplasty	6710	Acrylic (Plastic)
2120	Amalgam - Two Surface	4220	Gingival Curettage and Root Planing	6720	Acrylic Veneer
2130	Amalgam - Three Surface	4260	Osseous Surgery	6740	Porcelain
2131	Amalgam - Four Surface	4270	Soft Tissue Graft Procedure	6750	Porcelain with Gold
<b><u>PERMANENT TEETH</u></b>		4330	Occlusal Adjustment (Limited)	6780	Gold 3/4 Cast
2140	Amalgam - One Surface	4331	Occlusal Adjustment (Complete)	6790	Gold Full Cast
2150	Amalgam - Two Surface	4341	Periodontal Scaling and Root Planing (Fewer than 12 Teeth)	<b><u>PONTICS</u></b>	
2160	Amalgam - Three Surface	4345	Periodontal Scaling Performed in the Presence of Gingival Inflammation	6210	Cast Gold
2161	Amalgam - Four Surface	4910	Periodontal Prophylaxis	6240	Porcelain to Gold
2310	Acrylic or Plastic - One Tooth	<b><u>PROSTHODONTICS - REMOVABLE</u></b>		6250	Acrylic with Gold
2330	Composite Resin - One Surface	5110	Complete Upper Denture	<b><u>GOLD INLAYS</u></b>	
2331	Composite Resin - Two Surfaces	5120	Complete Lower Denture	6520	Two Surfaces
2332	Composite Resin - Three Surfaces	5130	Immediate Upper Denture	6530	Three or More Surfaces
2510	Gold Inlay - One Surface	5140	Immediate Lower Denture	6540	Gold Onlay
2520	Gold Inlay - Two Surfaces	5150	Complete Upper and Lower Dentures	<b><u>EXTRACTIONS</u></b>	
2530	Gold Inlay - Three Surfaces	5210	Provisional without Clasps	7110	Simple - Single Tooth
2540	Gold Onlay	5211	Upper Partial - Acrylic Base	7120	Simple - Each Additional Tooth
<b><u>CROWN - SINGLE RESTORATION</u></b>		5212	Lower Partial - Acrylic Base	7220	Surgical - Soft Tissue Impaction
2710	Plastic (Acrylic)	5230	Partial Lower - Gold Lingual Bar and Two Clasps, Acrylic Base	7230	Surgical - Partial Boney Impaction
2720	Plastic with Gold	5231	Partial Lower - Chrome Lingual Bar and Two Clasps, Acrylic Base	7240	Surgical - Complete Boney Impaction
2740	Porcelain	5241	Partial Lower - Chrome Lingual Bar, Cast Base	9110	Palliative Treatment of Dental Pain
2750	Porcelain with Gold	5250	Partial Upper - Gold or Chrome Palatal Bar and Two Clasps, Acrylic Base		
2790	Gold - Full Cast	5261	Partial Upper Chrome Palatal Bar and Two Clasps, Acrylic Base		
2810	Gold - 3/4 Cast	6950	Precision Attachment		
2830	Stainless Steel Crown				
2840	Provisional or Temporary				
2891	Cast Post and Core (Additional)				

**WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)