DENTAL CLAIM FORM

MAIL TO: UMR PO Box 30541

Salt Lake City, UT 84130-0541

Part 1						TO BE COMPLETED BY EMPLOYEE														•				
1. PATIENT NAME						. RELAT	IONSHIP POUSE	TO EMP		THER	3. S	SEX F	4. PATIE			Έ								
5. EMPLOYEE NAME FIRST MIDDLE LAST												6.	EMPLOYEE SOCIAL SE		Y NO	7 NAME OF GROUP DENTAL PROGRAM CEBT								
8. EMPLOYEE MAILING ADDRESS											9. EMPLOYER (COMPANY) NAME AND ADDRESS													
CITY, STATE ZIP																								
10. GROUP CEBT 11. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME SOC SEC NO											NO ☐ YES ☐ 12. NAME AND ADDRESS OF EMPLOYER IN ITEM 13													
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO ☐ YES ☐	DEN	ITAL PL	AN NAME		UNIO	ON LOCA	L	GF	ROUP NO	0	N	IAME	AND ADDRES	SS OF	CARRIE	R								
Part 2 TO BE COMPLETED BY ATTENDING DENTIST I hereby certify to the above signature						statements						I authorize my attending dentist to release any information relating to the claim Patient's Signature (Parent if a minor) Date										/		
14. DENTIST NAME												22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?				NC	YES	IF YES, Et	NTER BRIE	F DESCRI	PTION AND DA	TES		П
15. MAILING ADDRESS												23. IS TREATMENT RESULT OF AUTO ACCIDENT? 24. OTHER ACCIDENT?												\dashv
CITY, STATE.						ZIP						25. ARE ANY SERVICES COVERED BY ANOTHER PLAN												
16. DENTIST SOC SEC OR TIN	SOC SEC OR TIN 17. DENTIST LICENSE NO.					18. DENTIST PHONE NO.						26. IF PROSTHESIS, IS THIS INITIAL PLACEMENT						(IF NO, REASON FOR 2' REPLACEMENT)				27. DATE OF PRIOR PLACEMENT		
19. FIRST VISIT DATE OF	20. P		F TREATMEN	NT 21 OTHER	1. RADIOGRAPHS OR NO YES HOW MANY					2	28. IS TREATMENT FOR ORTHODONTICS?						IF SERVICES ALREADY PLACED COMMENCED, ENTER			PPLIANCES	MOS TREATME REMAININ			
DENTIST — CHECK ONE PRETREATMENT ESTIMATE STATEMENT OF ACTUAL	EATMENT ESTIMATE USE CHARTING SYSTEM SHOWN												USE ONLY											
SERVICES IDENTIFY MISSING TEETH WITH 'X' FACIAL TOOTH # OR SURFACE LETTER					DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED						ED. E	D. ETC.) PERI			TE SERV ERFORM DAY	DRMED NUM		CEDURE IMBER FEE		EE	BASIC		MAJOR	_
																								\dashv
03 C H 130 02 OB LINGUAL 10 150 01 OA J 160																								\dashv
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©32@7 K@17@ ©31@5 LINGUAL L@18@	X																							\exists
030 0 R N N 020 0 022 0 0 0 21 0 0227 0 0 0 22 0	5																							\exists
FACIAL																								\exists
30. REMARKS FOR UNUSUAL SERVICES Part 4 TO BE COMPLE	TED	DV EI	MDI OVE	_				IMDO		NT —	DE	\D (CAREFUL	ıv	7	TOTA								\dashv
CERTIFICATION I hereby certify that I ha					e fees to b	oe charge		IIVIPO	JNIA	1111 —	NEF	AD C	JANEFUL	LT.	╁		applicab		Dardo	-416-1-				\dashv
EMPLOYEE'S SIGNATURE: ASSIGNMENT I hereby assign benefits payable to the attending dentist																	Dedu 9 Paya	6				\dashv		
EMPLOYEE'S SIGNATURE: DATE Part 5 TO BE COMPLETED BY DENTIST															Amt Payable									
I hereby certify that the services listed above have been performed on the above named patient on the dates indicated													\dagger	These benefits will be subject to policy provisions, be payable if the described procedures are performed during a period of the patient's eligibility. (The patient's personal eligibility has not been verified at the time of predermi-										
DENTIST'S SIGNATURE: DATE												\dagger	nation.) PLAN PAYS											
																			PATI PA		•			

DENTAL CLAIM INSTRUCTIONS

Before submitting your claim, make sure that all required information on the claim form has been completed and that you have signed the appropriate signature blocks. Failure to complete applicable information may **DELAY** payment of your claim.

TIMELY CLAIMS SUBMISSION: All claims are required to be submitted within 12 months of the date of service. If claims are not submitted within these guidelines, payment will not be assured.

- 1. **PART 1** Must be completed in its entirety by the **EMPLOYEE.** Be sure that #13 relating to the other group coverage is completed if applicable.
- 2. **PART 2** Is to be completed by the **DENTIST**, or a comparable dental form may be attached to the CEBT form.
- 3. When the claim is being submitted for payment, be sure that **PART 4** and **PART 5** are signed by the applicable people. If in **PART 4** you assign benefits, CEBT will make payment to the dentist; if you do not wish to assign benefits, CEBT will make payments to you.
- 4. If the claim is for **ORTHODONTICS**, the dentist needs to list the total fee, the class of malocclusion (diagnosis), how long the treatment will last, and the date that the appliances (braces) were placed.

MAIL CLAIMS TO:

UMR

PO Box 30541 Salt Lake City, UT 84130-0541

NOTE: PROVIDERS—FOR INFORMATION, PLEASE CALL (303) 773-1373