MUTUAL HEALTH SERVICES℠

# MERCER-AUGLAIZE EMPLOYEE BENEFIT TRUST

## DENTAL STATEMENT OF CLAIM

| | | |
|---|---|---|
| 1. EMPLOYEE NAME | 2. EMPLOYEE SOCIAL SECURITY NO. | IS THIS CLAIM: ☐ For Services Rendered ☐ Pre-Determination |
| 4. PATIENT NAME | 5. RELATIONSHIP TO EMPLOYEE | 6. PATIENT BIRTHDATE / IS THIS YOUR FIRST CLAIM? ☐ Yes ☐ No |

7. EMPLOYEE MAILING ADDRESS — CITY, STATE, ZIP

8. EMPLOYER (COMPANY)

9. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ No ☐ Yes — DENTAL PLAN NAME & ADDRESS

10. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO BELOW DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN BELOW

SIGNED (EMPLOYEE) IF YES, ABOVE

11. I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION

SIGNED (PATIENT)

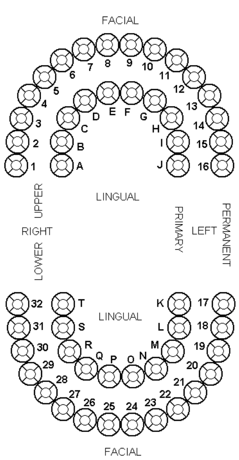
12. DENTIST NAME

13. MAILING ADDRESS

CITY, STATE, ZIP

| | NO | YES |
|---|---|---|
| 14. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | ☐ | ☐ |
| 15. IS TREATMENT RESULT OF AN ACCIDENT? | ☐ | ☐ |
| 16. ARE ANY SERVICES COVERED BY ANOTHER PLAN? | ☐ | ☐ |
| 17. IS TREATMENT FOR ORTHODONTICS? | ☐ | ☐ |

IDENTIFY MISSING TEETH WITH "X"




19. REMARKS FOR UNUSUAL SERVICES

18. EXAM AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH 1 THRU TOOTH 32 - USE CHARTING SYSTEM SHOWN

| Tooth # or Letter | Surface | Description of service (including x-rays, prophylasis, materials used, etc.) | Date Service Performed MO | DA | YR | Procedure Number | Fee | For Administrative Use Only |
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I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

| | | | |
|---|---|---|---|
| DENTIST SIGNATURE | DATE | Total Fee Charged | |
| | | MAX ALLOWABLE | |

PLEASE COMPLETE AND RETURN TO:
MUTUAL HEALTH SERVICES
P.O. BOX 4138, AKRON, OHIO 44321
800-367-3762

| | | |
|---|---|---|
| INDIVIDUAL PRACTITIONERS - SS NO. | | |
| ALL OTHERS - EMPLOYER ID NO. | | |