



Maine Municipal
Employees Health Trust
IN MAINE 1-800-852-8300
(207) 621-2645

DENTAL CLAIM FORM

TYPE OR PRINT

Before completing form,
please note reverse side.

CHECK ONE:

- DENTIST'S PRE-DETERMINATION ESTIMATE
 DENTIST'S STATEMENT OF ACTUAL SERVICES

| | | | | | | | | | |
|---|-----------------------------|--|--|--|------------------------------------|-------------|---|--------------|--|
| EMPLOYEE SECTION | 1. EMPLOYEE NAME | | | | A. EMPLOYEE SOCIAL SECURITY NUMBER | | | | |
| | B. NAME OF EMPLOYER | | | | C. DENTAL GROUP NUMBER | | | | |
| | 2. EMPLOYEE MAILING ADDRESS | | | | | | | | |
| | 3. PATIENT NAME | | 4. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER | | 5. SEX M F | | 6. PATIENT BIRTHDATE MO DAY YEAR | | 7. If Dependent is over 19, do you provide 50% of support? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 8. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | DENTAL PLAN NAME | | | UNION LOCAL | | GROUP NUMBER | |

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNED: (PATIENT, OR PARENT IF MINOR)

DATE

| | | | | | | | | | | |
|-----------------|--|--|---|--|---|--|---|--------------------------|--|--|
| DENTIST SECTION | 9. DENTIST NAME | | | | 17. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | | NO | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES | |
| | 10. MAILING ADDRESS | | | | 18. IS TREATMENT RESULT OF AUTO ACCIDENT? | | | | | |
| | CITY, STATE, ZIP | | | | 19. OTHER ACCIDENT? | | | | | |
| | 11. DENTIST SOC. SEC. OR T.I.N. | | 12. DENTIST LICENSE NO. | | 13. DENTIST PHONE NO. | | 20. ARE ANY SERVICES COVERED BY ANOTHER PLAN? | | | |
| | 14. FIRST VISIT DATE CURRENT SERIES | | 15. PLACE OF TREATMENT OFFICE HOSP ECF OTHER | | 16. RADIOGRAPHS OR MODELS ENCLOSED? <input type="checkbox"/> NO <input type="checkbox"/> YES | | 21. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? | | 22. DATE OF PRIOR PLACEMENT IF NO, REASON FOR REPLACEMENT | |
| | | | | | | | 23. IS TREATMENT FOR ORTHODONTICS? | | IF SERVICES ALREADY COMMENCED, ENTER: A | |
| | | | | | | | | DATE APPLIANCES PLACED | | |
| | | | | | | | | MOS. TREATMENT REMAINING | | |

| | | | | | | | | |
|----------------------------------|---|---------|--|---|--|------------------|-----|-----------------------------|
| IDENTIFY MISSING TEETH WITH "X" | 24. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 — USE CHARTING SYSTEM SHOWN. | | | | | | | FOR ADMINISTRATIVE USE ONLY |
| | TOOTH# OR LETTER | SURFACE | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NUMBER | DATE OF SERVICE PERFORMED MO. DAY YEAR | | PROCEDURE NUMBER | FEE | |
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| 25. REMARKS FOR UNUSUAL SERVICES | | | | | | | | |

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST): _____ DATE: _____

| | |
|-------------------|--|
| TOTAL FEE CHARGED | |
| MAX ALLOWABLE | |
| DEDUCTIBLE | |
| MMEHT# | |
| MMEHT PAYS | |
| EMPLOYEE PAYS | |

RETURN TO: 60 COMMUNITY DRIVE
AUGUSTA, ME 04330-9486

- Any proposed treatment in excess of \$300 *will require a pre-determination.*
(Check with the Health Trust for details)
- Employee must complete top section (1-8) of claim form including signature and date.
- Dentist must complete lower section (9-25) of claim form ***or attach*** completely itemized bills.
- Itemized bills should include employee's name, policy number, patient's name, diagnosis, date of service, type of service and amount charged for each service.
- Send all required documents to:

**MMEHT Dental Plan
60 Community Drive
Augusta, ME 04330-9486**