[redacted]

MEDICAL MUTUAL®
CAROLINA CARE PLAN | CONSUMERS LIFE
P.O. Box 6018 • Cleveland, Ohio 44101-1018

DENTAL

☐ ACTUAL SERVICES ☐ PRE-TREATMENT ESTIMATE
☐ ENCOUNTERED CLAIM

Z3226 R9/11 PLEASE PRINT OR TYPE SEE INSTRUCTIONS ON BACK

SUBSCRIBER COMPLETES THIS SECTION

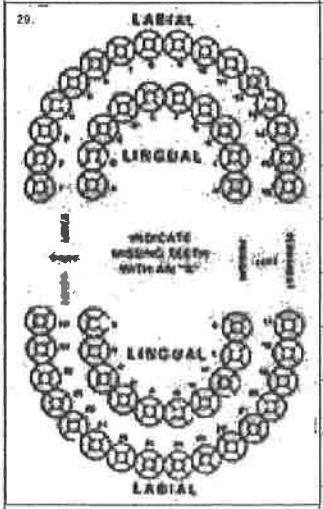
1. SUBSCRIBER'S LAST NAME | FIRST | M.I. (ACCURACY IMPORTANT)
2. EMPLOYER/GROUP NO.
3. CERTIFICATE NO. (ACCURACY IMPORTANT)
4. PAGE ____ OF ____
5. SUBSCRIBER'S ADDRESS — STREET NO. | STREET NAME | CITY | STATE | ZIP CODE
6. PATIENT'S LAST NAME | FIRST | M.I.
7. SEX
8. PATIENT'S BIRTHDAY MO. | DAY |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

DENTIST COMPLETES THIS SECTION

21. ARE X-RAYS ENCLOSED? YES ☐ NO ☐ IF YES INDICATE NUMBER ——

EXAMINATION & TREATMENT — LIST IN ORDER TOOTH #1 THROUGH TOOTH #32

22. LINE NO.	23. TOOTH NO OR LETTER	24. SURFACES	25. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	26. DATE SERV.COMP. MO DAY YR	27. FEE FOR EACH SERVICE COMPLETED	28. PROCEDURE CODE NO.
01						
02						
03						
04						
05						
06						
07						
08						
09						
10						

29. 

30. PLACE OF SERVICE: 1 ☐ IN-PATIENT 2 ☐ OUT-PATIENT 3. ☐ OFFICE 4. ☐ HOME

31. WERE SERVICES INDICATED RENDERED FOR ORTHODONTICS PURPOSES? YES ☐ NO ☐

33. DATE TOTAL ➤ FEE

32. IF PROSTHESIS/CROWN IS THIS AN INITIAL PLACEMENT? YES ☐ NO ☐ 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. 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)

WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. (Indiana Code IC 27-2-16-3)

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

SUBSCRIBER/PATIENT INSTRUCTIONS

USE THE CURRENT MEDICAL MUTUAL 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
DIAGNOSTIC AND PREVENTIVE	
0110	Initial Exam
0120	Periodic Exam
0210	Intra-Oral Complete Series (Including Bitewings) (Limited to once every three years)
0220	Intra-Oral First Film
0230	Intra-Oral Each Additional Film
0270	Bite-Wing X-Ray
0272	Bite-Wing Films, Two
0273	Bite-Wing Films, Three
0274	Bite-Wing Films, Four
0330	Panoramic - Maxilla and Mandible Film
0470	Diagnostic Casts
1110	Prophylaxis - Adult
1120	Prophylaxis - Child (Under age 12)
RESTORATIVE	
	(Multiple restorations in one surface will be considered a single restoration)
PRIMARY TEETH	
2110	Amalgam - One Surface
2120	Amalgam - Two Surface
2130	Amalgam - Three Surface
2131	Amalgam - Four Surface
PERMANENT TEETH	
2140	Amalgam - One Surface
2150	Amalgam - Two Surface
2160	Amalgam - Three Surface
2161	Amalgam - Four Surface
2310	Acrylic or Plastic - One Tooth
2330	Composite Resin - One Surface
2331	Composite Resin - Two Surfaces
2332	Composite Resin - Three Surfaces
2510	Gold Inlay - One Surface
2520	Gold Inlay - Two Surfaces
2530	Gold Inlay - Three Surfaces
2540	Gold Onlay
CROWN - SINGLE RESTORATION	
2710	Plastic (Acrylic)
2720	Plastic with Gold
2740	Porcelain
2750	Porcelain with Gold
2790	Gold - Full Cast
2810	Gold - 3/4 Cast
2830	Stainless Steel Crown
2840	Provisional or Temporary
2891	Cast Post and Core (Additional)

PROCEDURE CODE	DESCRIPTION OF SERVICE
OTHER RESTORATIONS AND RECEMENTING	
2910	Recement Inlays
2920	Recement Crown
2940	Sedative Filing
6930	Recement Bridge
ENDODONTICS	
3110	Pulp Cap Direct
3120	Pulp Cap Indirect
3220	Vital Pulpotomy
3310	Root Canal Therapy - One Canal
3320	Root Canal Therapy - Two Canals
3330	Root Canal Therapy - Three Canals
3340	Root Canal Therapy - Four Canals
3410	Apicoectomy (Separate Procedure)
3420	Apicoectomy (With Root Canal)
PERIODONTICS	
4210	Gingivectomy or Gingivoplasty
4220	Gingival Curretage and Root Planing
4260	Osseous Surgery
4270	Soft Tissue Graft Procedure
4330	Occlusal Adjustment (Limited)
4331	Occlusal Adjustment (Complete)
4341	Periodontal Scaling and Root Planing (Fewer than 12 Teeth)
4345	Periodontal Scaling Performed in the Presence of Gingival Inflammation
4910	Periodontal Prophylaxis
PROSTHODONTICS - REMOVABLE	
5110	Complete Upper Denture
5120	Complete Lower Denture
5130	Immediate Upper Denture
5140	Immediate Lower Denture
5150	Complete Upper and Lower Dentures
5210	Provisional without Clasps
5211	Upper Partial - Acrylic Base
5212	Lower Partial - Acrylic Base
5230	Partial Lower - Gold Lingual Bar and Two Clasps, Acrylic Base
5231	Partial Lower - Chrome Lingual Bar and Two Clasps, Acrylic Base
5241	Partial Lower - Chrome Lingual Bar, Cast Base
5250	Partial Upper - Gold or Chrome Palatal Bar and Two Clasps, Acrylic Base
5261	Partial Upper Chrome Palatal Bar and Two Clasps, Acrylic Base
6950	Precision Attachment

PROCEDURE CODE	DESCRIPTION OF SERVICE
PROSTHODONTICS - REMOVABLE (Cont'd)	
5730	Complete Denture Reline - Office
5740	Partial Denture Reline - Office
5750	Complete Denture Reline - Laboratory
5760	Partial Denture Reline - Laboratory
5850	Tissue Conditioning
DENTURE REPAIRS	
5610	Repair Complete or Partial Denture - No Teeth Involved
5610	Repair Complete or Partial Denture - Replace One Tooth
5630	Each Additional Tooth
5640	Replace Broken Tooth - No Other Repairs
5650	Add Tooth to Partial to Replace Extracted Tooth (Not Involving Clasp or Abutment)
5660	Add Tooth to Partial to Replace Extracted Tooth (Involving Clasp or Abutment)
5670	Reattaching Damaged Clasp on Denture
5680	Replacing Broken Clasp with New Clasp
PROSTHODONTICS - FIXED ABUTMENTS	
6710	Acrylic (Plastic)
6720	Acrylic Veneer
6740	Porcelain
6750	Porcelain with Gold
6780	Gold 3/4 Cast
6790	Gold Full Cast
PONTICS	
6210	Cast Gold
6240	Porcelain to Gold
6250	Acrylic with Gold
GOLD INLAYS	
6520	Two Surfaces
6530	Three or More Surfaces
6540	Gold Onlay
EXTRACTIONS	
7110	Simple - Single Tooth
7120	Simple - Each Additional Tooth
7220	Surgical - Soft Tissue Impaction
7230	Surgical - Partial Boney Impaction
7240	Surgical - Complete Boney Impaction
9110	Palliative Treatment of Dental Pain

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NASCODENT