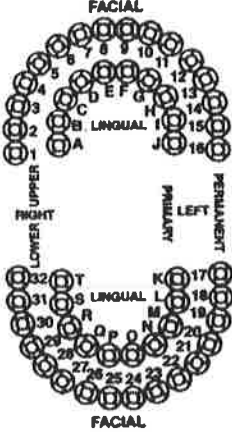


1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services Provider ID No. _____	2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization No. _____ Patient ID No. _____	3. Carrier name and Address <b>UMR</b> <b>PO Box 30541</b> <b>Salt Lake City, UT 84130-0541</b> <b>1-800-826-9781</b>																																																																																																																																																																																																																																																																																	
4. Patient name first _____ m i. _____ last _____	5. Relation to insured <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other	6. Sex m _____ f _____	7. Patient birthdate MM DD YYYY _____	8. If full time student school _____ city _____																																																																																																																																																																																																																																																																															
9. Employee/subscriber name and mailing address		10. Employee/subscriber soc sec number	11. Employee/subscriber birthdate MM DD YYYY _____	12. Employer (company) name and address	13. Group number																																																																																																																																																																																																																																																																														
14. Is patient covered by another dental plan? If yes, complete 15-A. <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient covered by a medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		15-A. Name and address of carrier(s)		15-B. Group No.(s)	16. Name and address of employer																																																																																																																																																																																																																																																																														
17-A. Employee/subscriber name (if different than patient's)		17-B. Employee/subscriber soc, sec, number	11. Employee/subscriber birthdate MM DD YYYY _____		18. Relationship to insured <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other																																																																																																																																																																																																																																																																														
19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.				20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity																																																																																																																																																																																																																																																																															
Signed (Patient, or parent if minor)				Signed (Employee/subscriber)																																																																																																																																																																																																																																																																															
<b>B I L L I N G D E N T I S T</b>	21. Name of Billing Dentist or Dental Entity		30. Is treatment result of occupational illness or injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, enter brief description and dates	31. Auto accident?																																																																																																																																																																																																																																																																														
22. Address of where payment should be remitted		23. City, State, Zip	32. Other accident?	<input type="checkbox"/> No <input type="checkbox"/> Yes	33. If prosthesis, is this initial placement?																																																																																																																																																																																																																																																																														
24. Dentist Soc Sec or T.I.N.	25. Dentist license No.	26. Dentist phone No.	34. Date of prior placement	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Flow Many?	35. Is treatment for orthodontics?																																																																																																																																																																																																																																																																														
27. First visit date current series		28. Place of treatment Office Hosp ECF Other		If services already commenced, enter:	Date appliances placed	Mos. treatment remaining																																																																																																																																																																																																																																																																													
36. Identify missing teeth with "X"		37. Examination and treatment plan - List in order from tooth No. 1 through tooth No. 32 - Use charting system shown.																																																																																																																																																																																																																																																																																	
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Tooth No. or letter</th> <th rowspan="2">Surface</th> <th rowspan="2">Description of Service (including x-rays, prophylaxis, materials, etc.) Line No.</th> <th colspan="3">Date Service Performed</th> <th rowspan="2">Procedure Number</th> <th rowspan="2">Fee</th> <th rowspan="2"></th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YYYY</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Tooth No. or letter	Surface	Description of Service (including x-rays, prophylaxis, materials, etc.) Line No.	Date Service Performed			Procedure Number	Fee		MM	DD	YYYY																																																																																																																																																																																																																																																																						For administrative use only
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38. Remarks for unusual services																																																																																																																																																																																																																																																																																			
39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.				41. Total Fee Charged	42. Payment by other plan	Max allowable																																																																																																																																																																																																																																																																													
( Treating Dentist ) _____ License Number _____ Date _____				Deductible	Carrier %	Carrier pays																																																																																																																																																																																																																																																																													
40. Address where treatment was performed  City _____ State _____ Zip _____				Patient pays																																																																																																																																																																																																																																																																															

## INSTRUCTIONS FOR COMPLETING THIS FORM

Please check with your provider before completing this form. UMR accepts dental claims electronically through the following clearinghouse:

Emdeon (Formerly Web MD)  
Phone: 1-888-416-0673  
Payer ID: 39026

Sending claims electronically eliminates the need for paper forms and allows for faster and more accurate submission of data.

If your provider has questions regarding this process, they may contact Envoy/Web MD or call the UMR EDI unit at 1-800-826-9781.

Below is an explanation to aid in completing the 'Patient Coverage' section of this form.

4. Patient's name
5. Relationship of patient to the employee named in Box 9.
6. Sex of patient
7. Birthdate of patient
8. Name of school and city where located if patient is age 19 or older and a full-time student
9. Employee's name and address
10. Employee's Social Security number
11. Birthdate of employee
12. Name of employee's employer
13. Group number of employee's dental plan
14. Question asking whether the patient has dental coverage through another plan other than the one named in Box 12 and whether the patient has coverage through a group medical plan
- 15-A. Name and address of other dental or medical carrier
- 15-B. Group number of other dental or medical carrier
16. Name and address of employer who provides the other dental or medical coverage
- 17-A. Name of the employee who has the other dental or medical coverage
- 17-B. Social Security number of employee named in Box 17-A
- 17-C. Birthdate of employee named in Box 17-A
18. Relationship of patient to employee named in Box 17-A