MUTUAL
HEALTH SERVICES™

DENTAL STATEMENT OF CLAIM

	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

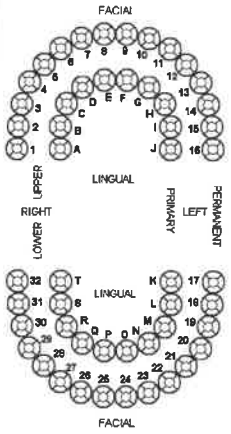
8. EMPLOYER (COMPANY)

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	11. I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION
SIGNED (EMPLOYEE) IF YES, ABOVE	SIGNED (PATIENT)

12. DENTIST NAME		NO	YES
	14. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	☐	☐
13. MAILING ADDRESS	15. IS TREATMENT RESULT OF AN ACCIDENT?	☐	☐
	16. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	☐	☐
CITY, STATE, ZIP	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

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

Total Fee Charged

DENTIST SIGNATURE — DATE — MAX ALLOWABLE

PLEASE COMPLETE AND RETURN TO:

MUTUAL HEALTH SERVICES
P.O. BOX 5700, CLEVELAND, OHIO 44101
800-367-3762

INDIVIDUAL PRACTITIONERS - SS NO.

ALL OTHERS - EMPLOYER ID NO.