



MEDICAL MUTUAL<sup>®</sup>  
Your healthcare partner since 1934

P.O. Box 6018  
Cleveland, Ohio 44101-1018

# DENTAL

ACTUAL SERVICES     PRE-TREATMENT ESTIMATE  
 ENCOUNTERED CLAIM

Z3226 R1/02 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.  418470		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. <input type="checkbox"/> SELF    3. <input type="checkbox"/> DEPENDENT CHILD 2. <input type="checkbox"/> SPOUSE    4. <input type="checkbox"/> FULL TIME STUDENT    5. <input type="checkbox"/> HANDICAPPED 6. <input type="checkbox"/> DEPENDENT CHILD AGE 18 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 <input type="checkbox"/> NO <input type="checkbox"/>		16. DATE OF ACCIDENT MO. DAY YEAR	
17. IF ACCIDENT, DID IT OCCUR ON THE JOB? YES <input type="checkbox"/> NO <input type="checkbox"/>		18. IF ACCIDENT, WAS ANOTHER PERSON INVOLVED? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 REMBURSEMENT. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> Signature of certificate holder or spouse _____ Date _____							

SUBSCRIBER COMPLETES THIS SECTION

### DENTIST COMPLETES THIS SECTION

21. ARE X-RAYS ENCLOSED? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES INDICATE NUMBER _____		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													
30. PLACE OF SERVICE 1 <input type="checkbox"/> IN-PATIENT    3 <input type="checkbox"/> OFFICE 2 <input type="checkbox"/> OUT-PATIENT    4 <input type="checkbox"/> HOME		31. WERE SERVICES INDICATED RENDERED FOR ORTHODONTICS PURPOSES? YES <input type="checkbox"/> NO <input type="checkbox"/>		32. IF PROSTHESIS/CROWN IS THIS AN INITIAL PLACEMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, DATE OF PRIOR PLACEMENT AND REASON TO REPLACE		33. DATE TOTAL > FEE		34. GRAND TOTAL > FEE							
37. PROVIDER NAME and ADDRESS						35. ADDITIONAL REMARKS FOR UNUSUAL SERVICES OR NARRATIVE FOR PREDETERMINATION									
38. TAX IDENTIFICATION NUMBER AND SUFFIX						39. OFFICE PHONE NO.									
SIGNATURE						DATE									

DENTIST COMPLETES THIS SECTION

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.

**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 Bite-wings) (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 Curettage 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

**PONICS**

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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