MEDICAL AND DENTAL CLAIM FORM

A. PARTICIPANT INFORMATION

Participant name: _____ Birth date (MM/DD/YYYY): _____

DMBA ID number: _____ Email: _____

Home address: _____ City: _____ State: _____ ZIP code: _____

Home phone: _____ Work phone: _____

Patient name: _____ Birth date (MM/DD/YYYY): _____

Patient's relationship to participant: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

B. PROVIDER INFORMATION

Provider name: _____ Phone number: _____

Tax Identification Number (TIN): _____ National Provider Identifier (NPI): _____

Provider type: ☐ Medical ☐ Dental

C. PAYMENT METHOD

Who do you wish to receive payment? ☐ Service provider ☐ Participant

I certify this information is true and complete. I authorize DMBA, healthcare providers, and/or persons or entities retained by DMBA for the purpose of auditing claims to secure or release information relating to this claim. I understand, agree, and consent that this authorization shall remain in effect indefinitely.

Signature: _____ Date (MM/DD/YY): _____

D. ACCIDENT INFORMATION

Is treatment the result of an accident? ☐ Yes (accident date: _____) ☐ No (proceed to section E)

Describe location and condition of injury: _____

How did the accident happen? _____

Where did the accident happen? _____

Was the accident related in any way to: Patient's employment? ☐ Yes ☐ No Auto accident? ☐ Yes ☐ No

Is there someone else who may be liable to pay for these expenses (a third party, etc.)? ☐ Yes ☐ No

If you answer "yes" to any of the questions above, please complete the *Accident Information Request Form* in the *Forms Library* on www.dmba.com.

E. OTHER INSURANCE INFORMATION

Is the patient covered by any other group insurance, health maintenance organization (HMO), or government plan (including Medicare)?

☐ Yes (complete the following information) ☐ No

Insurance company name: _____

Policy holder name: _____

Policy number: _____

HELP US PROCESS YOUR CLAIM

1. You must include a properly completed and signed claim form each time you submit a bill.
2. Attach an itemized bill from the service provider that includes the following:

MEDICAL SERVICES

- Date of service
- Diagnosis codes
- Procedure codes
- Place of service
- Amount charged for each service
- Provider name, address, and phone number
- Provider TIN
- Provider NPI

DENTAL SERVICES

- Date of service
- Procedure codes
- Tooth numbers and surfaces
- Place of service
- Amount charged for each service
- Provider name, address, and phone number
- Provider TIN
- Provider NPI

3. Claims must be submitted within 12 months from the date the service was rendered. Claims received after this date will not be eligible for benefits.
4. Send the claim form and itemized bills to:

   DMBA
   P.O. Box 45530
   Salt Lake City, UT 84145

When the claim has been processed, you will receive an Explanation of Benefits (EOB) from DMBA explaining how your claim has been handled. If you have any questions, please contact DMBA:

Salt Lake City area	801-578-5600
Toll free	800-777-3622

NOTE: Be sure to complete all of the requested information. If you don't, processing of your claim may be delayed.

Please return this completed form to DMBA, P.O. Box 45530, Salt Lake City, Utah 84145-0530, or fax it to 801-578-5901.
For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.