

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 <div style="text-align: center;">UMR PO Box 30541 Salt Lake City, UT 84130-0541 1-800-826-9781</div> <div style="float: right; text-align: right;"></div>
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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
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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
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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
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17-A. Employee/subscriber name (if different than patient's)	17-B. Employee/subscriber soc. sec. number	18. 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
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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. Signed (Patient, or parent if minor) _____	20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity Signed (Employee/subscriber) _____
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B I L L I N G D E N T I S T	21. Name of Billing Dentist or Dental Entity				30. Is treatment result of occupational illness or injury? No Yes	If yes, enter brief description and dates		
	22. Address of where payment should be remitted							
	23. City, State, Zip							
	24. Dentist Soc Sec or T.I.N.	25. Dentist license No.	26. Dentist phone No.			31. Auto accident?	32. Other accident?	
	27. First visit date current series	28. Place of treatment Office Hosp ECF Other	29. Radiographs	<input type="checkbox"/> No <input type="checkbox"/> Yes How Many?	33. If prosthesis, is this initial placement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	34. Date of prior placement	

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.						For administrative use only
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Tooth No. or letter	Surface	Description of Service (including x-rays, prophylaxis, materials, etc.) Line No.	Date Service Performed MM DD YYYY			Procedure Number	Fee	For administrative use only								

38. Remarks for unusual services	41. Total Fee Charged 42. Payment by other plan Max allowable
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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. _____ (Treating Dentist) License Number Date	41. Total Fee Charged 42. Payment by other plan Max allowable Deductible Carrier % Carrier pays Patient pays
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40. Address where treatment was performed _____	City State Zip	
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INSTRUCTIONS FOR COMPLETING THIS FORM

Please check with your provider before completing this form. Dental Providers may submit UMR dental claims electronically free of charge from the clearinghouse Optum360:

Email: optum360@optum.com
Phone: 1-866-223-4730
UMR 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 Optum360 or call the UMR EDI unit at 1-800-289-0287.

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