FORM MDC

CLAIM FOR DENTAL CARE

Please print or type information

Mail all claims and inquiries to the Fund Office of the

MAN-U SERVICE CONTRACT TRUST FUND
7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046
Toll Free (800) 638-8824

FOR FUND OFFICE USE ONLY	
Contractor:	Period Elig.:
Contract:	Class: Rate:

MEMBER INFORMATION

Name (First name, middle initial, last name)	Birth Date	Social Security Number	Married ( ) Single ( )

Address (Street, city, state, zip code)	Telephone Number Home: Work:	Name of Employer & Local #

PATIENT INFORMATION

Name (First name, middle initial, last name)	Birth Date	Relationship to Member Self Spouse Child Other	☐ Male ☐ Female

Is the patient covered under another Dental Benefits Plan? ☐ Yes ☐ No If yes: carrier name _____

policy holder _____ policy number _____ effective date _____ Individual ☐ Family ☐

DENTIST OR SUPPLIER INFORMATION

DENTIST NAME FIRST MIDDLE LAST			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS			IS TREATMENT RESULT OF AUTO ACCIDENT?			
			OTHER ACCIDENT?			
CITY, STATE	ZIP		ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC. SEC. OR T.I.N.	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE HOSP. ECF OTHER	RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?	IS TREATMENT FOR ORTHODONTICS?	NO	YES	IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

Description of Services

Tooth No. or Letter	Surfaces*	Detailed description of services, including x-rays (show quantity, materials, etc.)	Date of Service M	D	Y	A.D.A. Procedure Code	Total Chg. Each Serv.

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CAT.	DIST.	PROC. CODE	QTY.	C.O.B.	COM.	ESTIMATE

NOTE: If Pretreatment Estimate, Dentist must have authorization from Fund Office before performing the services. (SEE REVERSE SIDE OF THIS FORM).

Processed By: _____ Date: _____

Entered By: _____ Date: _____

TOTAL CHARGES . . . . . $ _____

PAYMENT CREDITS-PATIENT . . . . . $ _____

PAYMENT CREDITS - OTHER CARRIER(S) . . . . . $ _____

BALANCE DUE . . . . . $ _____

CHECK ONE: ☐ DENTIST'S PRETREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

I have reviewed the foregoing treatment plan, I authorize release of any information relating to this claim.

SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____

I hereby certify that the services listed above, will be ☐ have been ☐ performed.

SIGNED (DENTIST) _____ DATE _____

I hereby authorize payment directly to the above-named dentist of the benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

SIGNED (MEMBER) _____ DATE _____

(FOR FUND OFFICE USE)

PRE-TREATMENT AUTHORIZATION

THE CALENDAR YEAR MAXIMUM DENTAL BENEFIT IS $3,000.00 FOR ELIGIBLE FAMILY GROUP OF MAN-U SERVICE CONTRACT TRUST FUND. BENEFITS ARE PAID ACCORDING TO THE FEE SCHEDULE APPROVED BY THE MAN-U SERVICE BOARD OF TRUSTEES.

THE FUND'S ADMINISTRATIVE OFFICE AUTHORIZES A MAXIMUM PAYMENT OF $ _____ FOR SERVICES TO BE RENDERED TO THE PATIENT, AS DESCRIBED ON THE FRONT OF THIS FORM.

IN THE EVENT THAT CLAIMS ARE RECEIVED AND PAID PRIOR TO THE RECEIPT OF THIS PRE-AUTHORIZED CLAIM, DENTAL BENEFITS FOR THIS PATIENT WILL BE SUBJECT TO THE MAXIMUM DENTAL BENEFIT AS STATED ABOVE.

AUTHORIZED BY: _____ DATE: _____

APPROVED BY: _____ DATE: _____