1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider ID No.

2. ☐ Medicaid Claim
☐ EPSDT
Prior Authorization No.
Patient ID No.

3. Carrier name and Address
UMR
PO Box 30541
Salt Lake City, UT 84130-0541
1-800-826-9781

4. Patient name — first m.i. last

5. Relation to insured — ☐ self ☐ child ☐ spouse ☐ other

6. Sex — m f

7. Patient birthdate — MM DD YYYY

8. If full time student — school city

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

14. Is patient covered by another dental plan? If yes, complete 15-A. ☐ Yes ☐ No
Is patient covered by a medical plan? ☐ Yes ☐ No

15-A. Name and address of carrier(s)

15-B. Group No.(s)

16. Name and address of employer

17-A. Employee/subscriber name (if different than patient's)

17-B. Employee/subscriber soc. sec. number

11. Employee/subscriber birthdate — MM DD YYYY

18. Relationship to insured — ☐ self ☐ child ☐ spouse ☐ other

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 authroize payment of the dental benefits otherwise payable to me directly to the below named dental entity

Signed (Employee/subscriber)

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity

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.

27. First visit date current series

28. Place of treatment — Office Hosp ECF Other

29. Radiographs — No Yes How Many?

30. Is treatment result of occupational illness or injury? — No ☐ Yes ☐ If yes, enter brief description and dates

31. Auto accident? — No ☐ Yes ☐

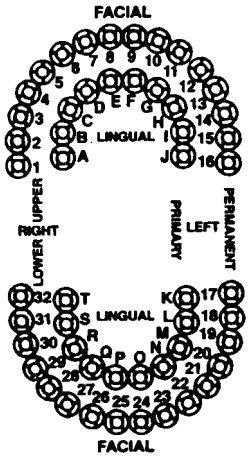
32. Other accident? — No ☐ Yes ☐

33. If prosthesis, is this initial placement? — No ☐ Yes ☐ (If no, reason for replacement)

34. Date of prior placement

35. Is treatment for orthodontics? — No ☐ Yes ☐ If services already commenced, enter: Date appliances placed Mos. treatment remaining

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.

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

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

40. Address where treatment was performed

City State Zip

41. Total Fee Charged $ 0.00

42. Payment by other plan

Max allowable

Deductible

Carrier % 0.00%

Carrier pays

Patient pays

RESET

A UnitedHealthcare Company

Instructions for completing this form

Please check with your provider before completing this form. Dental providers can submit UMR dental claims electronically free of charge from the clearinghouse with payor ID: **39026**. If your provider has questions regarding this process, they can contact **877-233-1800**.

You can submit your claim to UMR by **one of the following methods**. If you have questions or need assistance, please call the member phone number at **800-826-9781**.

EMAIL a PDF file of your claim and documents to:
UMR-ClaimSubmission@umr.com

FAX a PDF file of your claim and documents to:
877-292-0792

MAIL a PDF file of your claim and documents to:
UMR, PO Box 30541
Salt Lake City UT 84130-0541

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. Gender 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