

EXAMPLE: PRE AUTHORIZED TREATMENT CLAIM, - FILE W/ COPY OF PRE AUTHORIZATION LETTER TO ADDRESS ON REVERSE.

MMSO DENTAL INFORMATION SHEET

1. Patient's Name: <u>DOE, JOHN</u>	2. Rank/Rate <u>E5</u>	3. Social Security No: <u>123-45-6789</u>	4. Birth date: <u>01/01/00</u>	5. Date Filed: <u>31 JUL 01</u>
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6. Current Duty/Unit Address: <u>USARB MILWAUKEE</u> Command/Unit <u>310 W WISCONSIN AVE STE 600</u> Street Address <u>MILWAUKEE</u> City <u>(414) 297-4536</u> Duty/Unit phone number (with area code)	<u>WI9PAA</u> UIC <u>WI 53203</u> State Zip Code	7. Patient's Home Address: <u>123 MAIN ST</u> Street Address <u>MY HOME TOWN</u> City <u>(456) 789-1234</u> Home phone number (with area code)	<u>WI 12345</u> State Zip Code
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8. Branch Of Service:

USA USN _____ USMC _____ USAF _____ *USAR _____ *USNR _____ *USMCR _____ *USAFR _____

Army NG (Active) _____ *Army NG (Inactive) _____ Air NG (Active) _____ *Air NG (Inactive) _____ (Effective 10/01/2000)

Other _____ Please explain: _____

* If illness/injury occurred while on drill, annual, or inactive training, submit a copy of drill record, orders, muster sheet, or leave and earning statement.

9. Type of Care:

Emergency Care _____ Routine _____ Pre-Authorization Yes No _____

If Yes, Pre-Authorization number: 123456789101112131415

10. Did a Military Dental Clinic authorize the referral of this care? Yes No _____

If so, Name and location of referring dental Clinic: GREAT LAKES NAVAL CENTER
(Include a copy of the DD-2161 Referral for Civilian Medical Care form)

11. Name of Provider	Treatment Dates	Charges
<u>DR. YOU PULLEN</u>	<u>30 JUL 01</u>	<u>\$ 2,500</u>

12. Have bills been paid? Yes No _____

If yes, In full _____ In Part _____

If yes, By whom MYSELF, \$150, REMAINDER ON ACCT.

If member paid, submit the itemized bill(s), a SF 1164 (Claim for Reimbursement with the member's original signature), and proof of payment (front and back of canceled check, receipt, or itemized bill showing a zero balance).

13. Signature of patient or the person who is authorizing the release of health care records related to this injury/illness to MILMEDSUPPOFF. Signature validates information provided.

<u>John Doe</u> Signature	<u>31 Jul 01</u> Date signed	<u>Service Member or Sponsor</u> Relationship to Patient
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