

## MMSO DENTAL INFORMATION SHEET

| 1 Patient's Name  | 2 Pay Grade       | 3 Social Security No  | 4 Birth date | 5 Date Filed: |                             |                   |         |       |       |       |       |       |       |
|---|-------------------|---|--------------|---------------|-----------------------------|-------------------|---------|-------|-------|-------|-------|-------|-------|
| 6 Current Duty/Unit Address<br><br>Command/Unit _____ UIC/ OPFAC _____<br>Street Address _____<br>City _____ State _____ Zip Code _____<br>Duty/Unit phone number (with area code) _____  |                   | 7 Patient's Home Address<br><br>Street Address _____<br>City _____ State _____ Zip Code _____<br>Home phone number (with area code) _____ |              |               |                             |                   |         |       |       |       |       |       |       |
| 8 Branch Of Service<br>USA _____ USN _____ USMC _____ USAF _____ * USAR _____ * USNR _____ * USMCR _____ * USAFR _____<br>Army NG (Active) _____ * Army NG (Inactive) _____ Air NG (Active) _____ * Air NG (Inactive) _____<br>Other _____ Please explain _____<br>* If Reserve or Guard, Type of LOD: <input type="checkbox"/> ADMIN <input type="checkbox"/> INFORMAL <input type="checkbox"/> FORMAL<br>* When treatment was received member (If NOT on Active Duty) was on: <input type="checkbox"/> IDT <input type="checkbox"/> ADT <input type="checkbox"/> AT <input type="checkbox"/> ADSW |                   |   |              |               |                             |                   |         |       |       |       |       |       |       |
| 9 Type of Care:<br>Emergency Care _____ Routine _____ Was treatment Pre-Authorized by MMSO? Yes _____ No _____<br>If Yes, Pre-Authorization number: _____   |                   |   |              |               |                             |                   |         |       |       |       |       |       |       |
| 10 Did an active duty Military Dental Clinic authorize the referral of this care?    Yes _____ No _____<br>If so, Name and location of referring active duty Dental Clinic _____<br>(Requires a copy of the DD-2161 Referral for Civilian Medical Care form)  |                   |   |              |               |                             |                   |         |       |       |       |       |       |       |
| <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: left;">11 Name of Civilian Dentist</th> <th style="width: 25%; text-align: left;">Treatment Date(s)</th> <th style="width: 25%; text-align: left;">Charges</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>  |                   |   |              |               | 11 Name of Civilian Dentist | Treatment Date(s) | Charges | _____ | _____ | _____ | _____ | _____ | _____ |
| 11 Name of Civilian Dentist   | Treatment Date(s) | Charges   |              |               |                             |                   |         |       |       |       |       |       |       |
| _____   | _____             | _____   |              |               |                             |                   |         |       |       |       |       |       |       |
| _____   | _____             | _____   |              |               |                             |                   |         |       |       |       |       |       |       |
| 12 Have bills been paid? Yes _____ No _____            If yes: In full _____ In part _____<br>If yes, By whom _____<br>If member paid, submit the itemized bill(s), a SF 1164 (Claim for Reimbursement for Expenditures on Official Business 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 MMSO Signature validates information provided and verifies dental treatment listed on claim form has been completed<br><br>_____ Date signed _____<br>Signature of service member patient<br>OR<br>_____ Printed name _____ Phone _____ Date _____<br>Signature of Military Unit Representative   |                   |   |              |               |                             |                   |         |       |       |       |       |       |       |