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:

_____ _____
Command/Unit UIC/ OPFAC

_____
Street Address

_____ _____ _____
City State Zip Code

_____
Duty/Unit phone number (with area code)

7. Patient's Home Address:

_____
Street Address

_____ _____ _____
City State Zip Code

_____
Home phone number (with area code)

8. Branch Of Service:

USA__X___ USN_____ USMC_____ USAF_____ * USAR_____ * USNR_____ * USMCR_____ ***** USAFR_____

Army NG (Active)__X___ * Army NG (Inactive)_____ Air NG (Active)_____ * Air NG (Inactive)_____

Other_____ Please explain: _____

*** If Reserve or Guard, Type of LOD: [ ] ADMIN [ ] INFORMAL [ ] FORMAL**

*** When treatment was received member (If NOT on Active Duty) was on: [ ] IDT [ ] ADT [ ] AT [ ] ADSW**

9. Type of Care:

Emergency Care_____ Routine_____ Was treatment Pre-Authorized by MMSO? Yes_____ No_____

If Yes, Pre-Authorization number:_____

10. Did an active duty Military Dental Clinic authorize the referral of this care? Yes_____ No_____

If so, Name and location of referring active duty Dental Clinic: _____
(Requires a copy of the DD-2161 Referral for Civilian Medical Care form)

11.	Name of Civilian Dentist	Treatment Date(s)	Charges
	_____	_____	_____
	_____	_____	_____

12. Have bills been paid? Yes____ No____ If yes: In full_____ In part_____

If yes, By whom: _____

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.

_____ _____
Signature of service member patient Date signed

OR

_____ _____ _____ _____
Signature of Military Unit Representative Printed name Phone Date

(revised Mar 02)

MMSO DENTAL INFORMATION SHEET (Instructions)

1. **Purpose:** This information sheet is used by eligible members of the U.S. Navy, Army, Air Force, Marine Corps, Army and Air National Guard, including reservists (on active duty or in training) to request payment or reimbursement for **dental services** provided by a civilian healthcare provider. This form is not required for, or to be sent with, a pre-authorization request.

2. **Who fills out the sheet:** Patients are responsible for completing the MMSO Dental Information Sheet. For assistance, contact your military unit medical representative (MEDREP). If the patient or MEDREP needs further assistance, contact MMSO's Customer Service Department at **DSN 792-3950**, or call toll free at **1-888-647-6676**. For a copy of this sheet visit our website at **http://mmso.med.navy.mil**

3. **What information must be provided?** Answer each item. An incomplete information sheet will cause delays in processing and payment of your bill. If the information requested does not apply, indicate N/A (not applicable).

4. **Who must sign the MMSO Dental Information Sheet?** The patient **or** authorized person representing the service member's military unit (medical representative, health benefit advisor, or other person designated by the military unit commander). The signature validates the MMSO Dental Information Sheet, and for payment purposes certifies dental treatment listed on the claim form has been completed.

INSTRUCTIONS FOR FILING DENTAL CLAIMS

1. **When to file:** Submit claims immediately after treatment. Claims returned to the unit or member for additional information must be submitted within 45 days or they will be closed. Closed claims may be reopened for reconsideration on a case-by-case basis**. Failure to provide information needed to process the claim will result in the service member becoming personally responsible for paying the cost of treatment. Further delay could even affect the member's credit rating.**

2. **What documents must you provide?** Send the original MMSO Dental Information Sheet and itemized bills. American Dental Association (ADA) Standard Claim Form or similar format is preferred. (Balance due statements or accounting ledgers are not acceptable.) All bills submitted must contain (at a minimum):
    a. Provider's name, address, and provider's tax identification number
    b. Patient's name, address, social security number, and date of birth
    c. Date services or supplies were provided
    d. Tooth number (if applicable)
    e. ADA procedure code and description of each service or supply
    f. Itemized charge for each service or supply.

3. **How can a member be reimbursed (SF 1164)?** If payment was made directly to the Healthcare provider by the patient or representative, the patient must submit a Claim for Reimbursement for Expenditures on Official Business (SF 1164). Include the itemized bill and proof of payment (front and back of canceled check, receipt, or itemized bill showing a zero balance). Member's original signature must be in block 10 of the SF 1164 form.

4. **Where to file the claim:** Submit completed MMSO Dental Information Sheet with itemized bills and any supporting documentation to:

OFFICER IN CHARGE
MILITARY MEDICAL SUPPORT OFFICE (MMSO)
ATTN: DENTAL CLAIMS
PO BOX 886999
GREAT LAKES, IL 60088-6999

Privacy Act Statement

Sections 6201, 6202, and 6203 of Title 10 to U.S. Code authorized collection of this information. The purpose of this information is to evaluate eligibility for civilian health benefit and to issue payment upon verification of eligibility. The MMSO uses the information to process health care claims for payment; for review of claims related to possible third party liability cases and initiation of recovery actions; for referral to professional review organizations to control and review providers dental care; for disclosure to third party contacts without the consent of the individual, to respond to inquiries from congressional offices made at the request of the covered individual; and for medical boards. Information must be provided if you expect to have the claim paid by the Government. Failure to provide information will result in denial or delay in payment of the claim.

DEPARTMENT OF DEFENSE
ACTIVE DUTY/RESERVE FORCES DENTAL EXAMINATION

Form Approved
OMB No. 0720-0022
Expires Feb 28, 2006

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 105-85, Sec. 765; DoD Directive 6490.2; E.O. 9397.

PRINCIPAL PURPOSE(S): An assessment by a dentist of the state of your dental health for the next 12 months is needed to determine your fitness for prolonged duty without ready access to dental care.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delays in assessing your dental health needs for military service.

1. SERVICE MEMBER'S NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. BRANCH OF SERVICE
		Army National Guard
4. UNIT OF ASSIGNMENT	**5. UNIT ADDRESS**	

6. EXAMINATION RESULTS

Dear Doctor,

The individual you are examining is an Active Duty/Guard/Reserve member of the United States Armed Forces. This member needs your assessment of his/her dental health for worldwide duty. **Please mark (X) the block** that best describes the condition of the member, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. **This form is meant to determine fitness for prolonged duty without ready access to dental care and is not intended to address the member's comprehensive dental needs.**

	(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.
	(2) Patient has some oral conditions, but you **do not** expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).
	(3) Patient has oral conditions that you **do** expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: *(X the applicable block or specify in the space provided)*
	(a) **Infections:** Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
	(b) **Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.
	(c) **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
	(d) **Periodontal Conditions:** Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
	(e) **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
	(f) **Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

(4) If you selected Block (3) above, please circle the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) below:

(5) Were X-rays consulted?		YES		NO	IF YES, DATE X-RAY WAS TAKEN *(YYYYMMDD)*

7. DENTIST'S NAME *(Last, First, Middle Initial)*	8. DENTIST'S ADDRESS *(Street, City, State, 9-digit ZIP Code)*
9. DENTIST'S TELEPHONE NUMBER *(Include Area Code)*	

10. DENTIST'S SIGNATURE/STATE LICENSE NUMBER	11. DATE OF EXAMINATION *(YYYYMMDD)*