



University Corporation  
for Atmospheric Research

MAIL THIS FORM TO: CIGNA HealthCare Service Center  
P.O. Box 188037  
Chattanooga, TN 37422-8037

TELEPHONE: 1-888-336-8258 Toll Free

DO NOT USE STAPLES

|                                      |  |  |  |  |   |  |  |  |  |                                     |  |
|--------------------------------------|--|--|--|--|---|--|--|--|--|-------------------------------------|--|
| PART I - TO BE COMPLETED BY EMPLOYEE | 1. PATIENT NAME  |  | 2. RELATIONSHIP TO EMPLOYEE<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> |  | 3. SEX<br>M <input type="checkbox"/> F <input type="checkbox"/> |  | 4. PATIENT BIRTH DATE<br>Mo. Day Year  |  | 5. IF FULL TIME STUDENT<br>School City |                                     |  |
|                                      | 6. EMPLOYEE / MEMBER / SUBSCRIBER NAME (First, Middle, Last)   |  |  |  |   |  | 7. EMPLOYEE SOCIAL SECURITY NO.  |  |  | EMPLOYEE BIRTH DATE<br>Mo. Day Year |  |
|                                      | 8. EMPLOYEE MAILING ADDRESS<br>CITY, STATE, ZIP  |  |  |  |   |  | 9. COMPANY (EMPLOYER) NAME AND ADDRESS AND/OR DIVISION AND PLANT LOCATION<br><b>UCAR</b> |  |  |                                     |  |
|                                      | 10. ACCOUNT / POLICY #<br><b>3153744</b>   |  | 11. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, Member's Name SOCIAL SECURITY NO.       |  |   |  | 12. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 11            |  |  | SPOUSE BIRTH DATE<br>Mo. Day Year   |  |
|                                      | 13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate  |  | DENTAL PLAN NAME   |  | GROUP NO.   |  | NAME AND ADDRESS OF CARRIER  |  |  |                                     |  |
|                                      | AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature. |  |  |  |   |  | SIGNED (PATIENT OR PARENT IF MINOR)  |  |  | DATE                                |  |
|                                      | AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.  |  |  |  |   |  | SIGNED (EMPLOYEE)  |  |  | DATE                                |  |
|                                      | CERTIFICATION - I certify that the foregoing information is true and correct.  |  |  |  |   |  | SIGNED (EMPLOYEE)  |  |  | DATE                                |  |

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

|  |  |  |  |  |  |     |  |  |  |  |                                |  |     |  |
|--|--|--|--|--|--|-----|--|--|--|--|--------------------------------|--|-----|--|
| PART II - TO BE COMPLETED BY ATTENDING DENTIST | 14. DENTIST NAME   |  | 22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?   |  | NO   | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES                                    |  |  |  |                                |  |     |  |
|  | 15. MAILING ADDRESS<br>CITY, STATE, ZIP  |  | 23. IS TREATMENT RESULT OF AUTO ACCIDENT?  |  |  |     |  |  |  |  |                                |  |     |  |
|  | 16. TAX I.D. # TO BE USED FOR TAX REPORTING. TAX I.D. #  |  | 24. OTHER ACCIDENT?  |  |  |     |  |  |  |  |                                |  |     |  |
|  | 17. DENTIST LICENSE NO.  |  | 18. DENTIST PHONE NO.  |  | 25. ARE ANY SERVICES COVERED BY ANOTHER PLAN?  |     | IF YES, NAME OF OTHER PLAN:  |  |  |  |                                |  |     |  |
|  | 19. FIRST VISIT DATE CURRENT SERIES  |  | 20. PLACE OF TREATMENT<br>Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other <input type="checkbox"/> |  | 21. RADIOGRAPHS OR MODELS ENCLOSED? <input type="checkbox"/> Yes <input type="checkbox"/> No |     | 26. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?                                |  | (IF NO, REASON FOR REPLACEMENT)        |  | 27. DATE OF PRIOR PLACEMENT    |  |     |  |
|  | 28. IS TREATMENT FOR ORTHODONTICS?   |  | 29. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32-USE CHARTING SYSTEM SHOWN                                     |  | IF SERVICES ALREADY COMMENCED, ENTER   |     | DATE APPLIANCES PLACED   |  | MOS. TREATMENT REMAINING               |  |                                |  |     |  |
|  | CHECK ONE:<br><input type="checkbox"/> PREDETERMINATION OF BENEFITS<br><input type="checkbox"/> Statement of Actual Services |  | TOOTH # OR LETTER  |  | SURFACE (i.e., M, O, D, B, L, LA, I)   |     | DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis, Materials Used, Etc.) |  | DATE SERVICE COMPLETED<br>Mo. Day Year |  | PROCEDURE NUMBER (See Reverse) |  | FEE |  |
|  | 30. Remarks for unusual services   |  |  |  |  |     |  |  |  |  |                                |  |     |  |

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.

SIGNED (DENTIST)

DATE

TOTAL FEE CHARGED

**INSTRUCTIONS**

**FOR THE EMPLOYEE**

1. Please answer all questions in Part I entitled "TO BE COMPLETED BY EMPLOYEE".
2. Sign and Date the "Authorization to Release Information".
3. If you wish to have your benefits paid directly to the Dentist, sign and date the "Authorization to pay Benefits to Dentist".  
If authorized, payment will be made directly to your Dentist. A copy of the payment will be sent to you for your records. Otherwise, payment will be made directly to you.
4. If the patient has coverage under any other group or Government plan, submit the same bills to the other plan at the same time.

**FOR THE DENTIST**

- For claims involving Predetermination of Benefits:
1. Complete the section "TO BE COMPLETED BY ATTENDING DENTIST". Be sure to itemize charges for each proposed procedure.
  2. CIGNA HealthCare will review the treatment plan and will provide the estimate of benefits payable.
  3. Review the form and benefit estimates with your patient before the work is done.
  4. When you complete treatment, return the form with the treatment dates completed and your signature.
- For claims not involving Predetermination of Benefits:
1. Complete Part II. Be sure to date and itemize charges.
  2. Sign and date bottom of claim form when work is completed.

The following supportive documentation, as indicated below, may be necessary to determine benefits:

- A. Pre-operative X-rays and/or Narrative
- B. Periodontal Case Type and Pocket Depth Chart
- C. Narrative

**PLEASE NOTE: IF THE CLAIM FORM IS NOT COMPLETED IN FULL AND SERVICES ARE NOT COMPLETELY ITEMIZED, PROCESSING OF PAYMENT WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED.**

**DENTAL PROCEDURE REFERENCE LIST**

|  |  |  |  |
|--|--|--|--|
| <p><b>I. DIAGNOSTIC / GENERAL</b></p> <p>Examinations<br/>0120 Periodic Oral Examination<br/>0150 Comprehensive Oral Examination</p> <p>Radiographs<br/>0210 Intraoral - complete series (including bitewings)<br/>0220 Intraoral - single, first film<br/>0230 Intraoral - each additional film<br/>0272 Bitewing, two films<br/>0274 Bitewing, four films<br/>0330 Panoramic - maxillary and mandibular - single film</p>  | <p><b>III. Restorative (Con't.)</b></p> <p><b>A</b> Gold Onlay Restorations<br/>2543 Onlay, gold - three surfaces<br/>2544 Onlay, gold - four or more surfaces</p> <p><b>A</b> Crowns - Single Restorations Only<br/>2710 Crown resin<br/>2720 Crown resin with high noble<br/>2721 Crown resin with predominately base metal<br/>2722 Crown resin with noble metal<br/>2740 Crown porcelain<br/>2750 Crown porcelain fused to high noble metal<br/>2751 Crown porcelain fused to predominately base metal<br/>2752 Crown porcelain fused to noble metal<br/>2790 Crown full cast high noble metal<br/>2791 Crown full cast predominately base metal<br/>2792 Crown full cast noble metal<br/>2810 Crown 3/4 cast metal<br/>2930 Prefabricated stainless steel crown - primary<br/>2931 Prefabricated stainless steel crown - permanent<br/>2932 Prefabricated resin crown</p> <p>Other Restorative Services<br/>2910 Recement inlays<br/>2920 Recement crowns</p> | <p><b>VI. PROSTHODONTICS - REMOVABLE</b></p> <p><b>C</b> Complete Dentures<br/>5110 Complete upper<br/>5120 Complete lower<br/>5130 Immediate upper<br/>5140 Immediate lower</p> <p><b>A</b> Partial Dentures<br/>5211 Upper, resin base, including clasps<br/>5212 Lower, resin base, including clasps<br/>5213 Upper, cast metal base<br/>5214 Lower, cast metal base</p> <p>Adjustments to dentures (6 mos. after installation or by dentist other than dentist providing appliances)<br/>5410 Complete denture (upper)<br/>5411 Complete denture (lower)<br/>5421 Partial denture (upper)<br/>5422 Partial denture (lower)</p> <p>Repair broken complete or partial denture<br/>5610 Repair denture base<br/>5620 Repair cast framework<br/>5630 Repair or replace broken clasp<br/>5640 Replace one broken tooth</p> <p>Adding teeth to partial to replace extracted tooth:<br/>5650 Each tooth not involving clasp<br/>5660 Each tooth involving clasp<br/>5730 Reline complete upper denture - chairside<br/>5731 Reline complete lower denture - chairside<br/>5740 Reline upper partial denture - chairside<br/>5741 Reline lower partial denture - chairside<br/>5750 Reline complete upper denture - laboratory<br/>5751 Reline complete lower denture - laboratory<br/>5760 Reline upper partial denture - laboratory<br/>5761 Reline lower partial denture - laboratory</p> | <p><b>VII. Prosthodontics - Fixed (Con't.)</b></p> <p><b>A</b><br/>6780 Abutment crown 3/4 cast high noble metal<br/>6790 Abutment crown full cast high noble metal<br/>6791 Abutment crown full cast predominately base metal<br/>6792 Abutment crown full cast noble metal<br/>2810 Crown 3/4 cast metal</p> <p>Other services<br/>6930 Recement bridge</p>  |
| <p><b>II. PREVENTATIVE</b></p> <p>Dental Prophylaxis (including scaling &amp; polishing)<br/>1110 Adults<br/>1120 Children under 14</p> <p>Fluoride Treatments<br/>1201 Topical application of fluoride, including prophylaxis - Child<br/>1203 Topical application of fluoride, excluding prophylaxis - Child<br/>1204 Topical application of fluoride, excluding prophylaxis - Adult<br/>1205 Topical application of fluoride, including prophylaxis - Adult</p> <p><b>C</b> Space Maintainers<br/>1510 Fixed, unilateral type<br/>1515 Fixed, bilateral type<br/>1520 Removable, unilateral type<br/>1525 Removable, bilateral type</p>   | <p><b>IV. ENDODONTICS</b></p> <p>Pulpotomy (excluding restoration)<br/>3220 Therapeutic pulpotomy</p> <p><b>A</b> Root Canal Therapy<br/>3310 Anterior<br/>3320 Bicuspid<br/>3330 Molar</p> <p><b>A</b> Endodontic Retreatment<br/>3346 Retreatment of previous anterior<br/>3347 Retreatment of previous bicuspid<br/>3348 Retreatment of previous molar</p> <p><b>A</b> Periradicular Services<br/>3410 Apicoectomy, performed as a separate surgical procedure, anterior (first root)<br/>3421 Apicoectomy, performed as a separate surgical procedure, bicuspid (first root)<br/>3425 Apicoectomy, performed as a separate surgical procedure, molar (first root)<br/>3426 Apicoectomy, performed as a separate surgical procedure, each additional root</p>   | <p><b>VII. PROSTHODONTICS - FIXED</b></p> <p>Fixed Bridges</p> <p><b>A</b> Bridge Pontics<br/>6210 Pontic cast high noble metal<br/>6211 Pontic cast predominately base metal<br/>6212 Pontic cast noble metal<br/>6240 Pontic porcelain fused to high noble metal<br/>6241 Pontic porcelain fused to predominately base metal<br/>6242 Pontic porcelain fused to noble metal<br/>6250 Pontic resin with high noble metal<br/>6251 Pontic resin with predominately base metal<br/>6252 Pontic resin with noble metal</p> <p><b>A</b> Inlay/Onlay Abutments<br/>6520 Inlay metallic - two surfaces<br/>6530 Inlay metallic - three surfaces<br/>6543 Onlay metallic - three surfaces<br/>6544 Onlay metallic - four or more surfaces</p>  | <p><b>VIII. ORAL SURGERY</b></p> <p>(All procedures include local anesthesia and post-operative care)</p> <p><b>A</b> Simple Extractions<br/>7110 Single tooth<br/>7120 Each additional tooth</p> <p><b>A</b> Surgical Extractions<br/>7210 Erupted tooth<br/>7220 Soft tissue impaction<br/>7230 Partial bony impaction<br/>7240 Complete bony impaction<br/>7241 Complete bony impaction presenting unusual difficulty and circumstances</p> <p><b>C</b> Alveoplasty (surgical preparation of ridge for dentures), per quadrant:<br/>7310 In conjunction with extractions<br/>7320 Not in conjunction with extractions</p>   |
| <p><b>III. RESTORATIVE</b></p> <p>Amalgam Restorations (deciduous teeth)<br/>2110 Amalgam - one surface<br/>2120 Amalgam - two surfaces<br/>2130 Amalgam - three surfaces<br/>2131 Amalgam - four or more surfaces</p> <p>Amalgam Restorations (permanent teeth)<br/>2140 Amalgam - one surface<br/>2150 Amalgam - two surfaces<br/>2160 Amalgam - three surfaces<br/>2161 Amalgam - four or more surfaces</p> <p>Silicate Restorations<br/>2210 Silicate cement - per restoration</p> <p>Filled or Unfilled Resin Restorations<br/>2330 Composite resin - one surface<br/>2331 Composite resin - two surfaces<br/>2332 Composite resin - three surfaces<br/>2335 Composite resin - four or more surfaces including the incisal angle</p> <p>2380 Composite resin - one surface, posterior - primary<br/>2381 Composite resin - two surfaces, posterior - primary<br/>2382 Composite resin - three surfaces, posterior - primary<br/>2385 Composite resin - one surface, posterior - permanent<br/>2386 Composite resin - two surfaces, posterior - permanent<br/>2387 Composite resin - three or more surfaces, posterior - permanent</p> <p><b>A</b> Gold Inlay Restorations<br/>2520 Inlay, gold - two surfaces<br/>2530 Inlay, gold - three surfaces</p> | <p><b>V. PERIODONTICS</b></p> <p><b>B</b> Surgical Services<br/>4210 Gingivectomy or gingivoplasty, per quadrant<br/>4260 Osseous surgery, per quadrant</p> <p><b>B</b> Adjunctive Services<br/>4341 Root Planing, per quadrant<br/>4355 Full mouth debridement<br/>9951 Occlusal adjustment - limited<br/>9952 Occlusal adjustment - complete</p> <p>Miscellaneous Services<br/>4910 Periodontal prophylaxis (periodontal maintenance procedures following active periodontal therapy)</p>  | <p><b>A</b> Crowns<br/>6720 Abutment crown resin with high noble metal<br/>6721 Abutment crown resin with predominately base metal<br/>6722 Abutment crown resin with noble metal<br/>6750 Abutment crown porcelain fused to high noble metal<br/>6751 Abutment crown porcelain fused to predominately base metal<br/>6752 Abutment crown porcelain fused to noble metal</p>   | <p><b>IX. ORTHODONTICS</b></p> <p>Comprehensive Full Banded Treatment<br/>8020 Preliminary Study (including cephalometric radiographs, diagnostic casts and treatment plan) and first month of active treatment including all active and retention appliances<br/>8030 Active treatment, per month after first month</p> <p>Other Orthodontic Treatment<br/>Appliances for Tooth Guidance<br/>8110 Removable<br/>8120 Fixed or cemented</p> <p>Appliances to Control Harmful Habits<br/>8210 Removable<br/>8220 Fixed or cemented</p> <p><b>X. ADJUNCTIVE SERVICES</b></p> <p>Emergency Treatment<br/>9110 Palliative (emergency) treatment of dental pain, minor procedures</p> <p><b>C</b> 9220 General anesthesia (first 30 minutes)<br/>9221 General anesthesia (each additional 15 minutes)</p> |