

South Carolina Medical Malpractice Association
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www.scmma.net

The South Carolina MMA is a not-for-profit association established to insure, support and defend South Carolina medical professionals. The association is managed by Marsh USA, Inc.

DENTAL AND ORAL SURGEON PROCEDURES REQUEST

Instructions: The procedures page must be signed and dated by the Insured. Please return this form via fax to 864-240-2750.

INSURED INFORMATION AND SPECIALTY CLASS:

1. **Name of Insured:** _____ **Email:** _____
2. **MMA Policy Number:** _____
3. **Current Policy Period:** ____/____/____ to ____/____/____
4. **Dates these procedures are effective:** ____/____/____

Please check the appropriate class in the far right column below. Any Procedure or Anesthesia in a higher class would make the higher class applicable.

Class	Procedure and / or Specialty	Anesthesia	Check Appropriate Class
1	General Dentistry Endodontics Pediatrics Prosthodontics Orthodontics Periodontics / Non-Osseous Surgery, Non-Advanced or Non-Refractory Progressive Periodontitis Prostheses / Non-Surgical Removal of Impacted Wisdom Teeth Soft Tissue Only	In the office: Local Nitrous Oxide Oral Conscious IV Administered in the hospital by other than an insured or insured's employee: General Deep Intra Muscular (I.M.)	<input type="checkbox"/> (1)
2	Periodontics / Osseous Surgery, Advanced or Refractory Progressive Periodontitis Removal of Impacted Wisdom Teeth, Other than Soft Tissue <i>Est. Percentage soft tissue</i> ____ <i>vs.</i> <i>other than soft tissue</i> ____.	Conscious I.M. in the office	<input type="checkbox"/> (2)
2A	Surgical Implants		<input type="checkbox"/> (2A)
3	Oral Surgeon Maxillofacial Surgery	General Anesthesia and / or Deep Sedation given in a dosage to render the patient unconscious and done in the office, or in a hospital if administered by an insured or insured's employee.	<input type="checkbox"/> (3)

OTHER PROCEDURES (INCLUDING BUT NOT LIMITED TO BOTOX AND OTHER INJECTABLES): _____

Have you provided acceptable documentation to the Dental Board as to your training, education, credentials and qualifications before undertaking to perform these procedures? ___ Yes ___ No Are all procedures limited to the perioral area? ___ Yes ___ No

_____/_____/_____
Signature of Insured **Date**