DENTAL CLAIM FORM

MONONGALIA COUNTY BOARD OF EDUCATION
DENTAL AND VISION BENEFIT PLAN

RETURN THIS FORM TO:
AMERICAN BENEFIT
3150 RT 60
ONA, WV 25545

PLEASE INDICATE
☐ Pre-Treatment Estimate (Services in Excess of $200)*
☐ Actual Charges

TO BE COMPLETED BY THE EMPLOYEE

Employee's Name ☐ Married ☐ Single Social Security Number

Employee's Address Number and Street City State Zip Code

Claim is For Dependent's Name Dependent's Date of Birth
☐ Self ☐ Spouse ☐ Child

Is the person for whom this claim is being made covered by any other group plan? ☐ Yes ☐ No

Name of Group Policy Number

Name of Insurance Company Address

I authorize release to Monongalia County Board of Education Dental Plan of any information required to process my claim. A photocopy of this authorization may be honored.

Employee's Signature

I hereby authorize payment directly to the named Dentist for the services described.

Employee's Signature

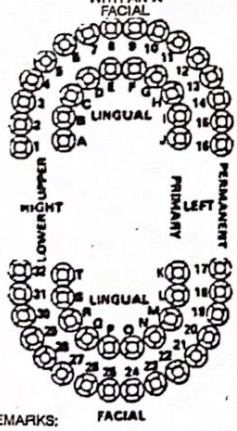
TO BE COMPLETED BY THE DENTIST

DENTIST			IS TREATMENT RESULT OF - OCCUPATIONAL ILLNESS OR INJURY?			IF YES, BRIEF DESCRIPTION AND DATES	
ADDRESS			IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?				
CITY, STATE, ZIP			ARE ANY SERVICES COVERED BY ANOTHER PLAN?				
DENTIST SOC. SEC. NO. OR TAX I.D. NO.	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT)	DATE OF PRIOR PLACEMENT
FIRST VISIT DATE	PLACE OF TREATMENT: OFFICE / HOSP / ECF / OTHER	RADIOGRAPHS OR MODELS ENCLOSED: NO / YES / HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING

PATIENT'S NAME

EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH 32
USE CHARTING SYSTEM SHOWN

INDICATE MISSING TEETH WITH AN X



REMARKS:

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE	
						TOTAL		

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATES INDICATED.

DENTIST'S SIGNATURE DATE:

*PLEASE NOTE: PRE-DETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT. This estimate has been calculated based on current available benefits and employee eligibility. This estimate is subject to modification based upon remaining benefits available and eligibility which applies at the time services are completed and claim is submitted for payment.