DENTAL CLAIM FORM

Please Indicate
___ Pre-Treatment Estimate (Services in Excess of $100)
___ Actual Charges

Return This Form To:
Mingo County Board of Education
3150 US Route 60
Ona, WV 25545

To Be Completed By the Employee
Employee's Name | Married | Single | Social Security Number XXX-XX-

Employee's Address | Number and Street | City | State | Zip Code

Claim is For Self Spouse Child Dependent's Name | Dependent's Date of Birth
If child is 19 years old or older is (s)he attending school on a full-time basis? ___ Yes ___ No

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

Name of School

Name of Group | Policy Number

Name of Insurance Company | Address

I authorize release to the above Plan any information required to process my claim. A photocopy of this authorization may be honored.

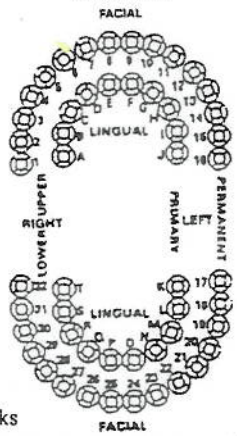
Employee's Signature

TO BE COMPLETED BY THE DENTIST

Dentist Name					Is treatment result of occupational illness or injury?			If Yes, enter brief description and dates		
Address					Is treatment result of auto accident? Other Accident?					
City, State, Zip					Are any services covered by another plan?					
Soc. Sec. No. or Tax ID 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	

Indicate Missing Teeth With an X

INDICATE MISSING TEETH WITH AN X



Examination and Treatment Plan – List in Order From Tooth No 1 Through 32
Use Charting System Shown

Tooth # or Letter	Surface	Description of Service Including X-Rays, Prophylaxis Materials Used. etc.	Date Service Performed MO	DAY	YR	Procedure Number	Fee	

Remarks

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

ee's Signature | Date:

y 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
The estimate of benefits 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.

Total	
Total Covered	
Total	
Plan Pays	
Patient Pays	