DENTAL CLAIM FORM

RETURN THIS FORM TO:
Hancock County Board of Education
Dental Plan
3150 US Route 60
Ona, WV 25545

PLEASE INDICATE
☐ Pre-Treatment Estimate (Services in Excess of $100)*
☐ Actual Charges

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 ttending 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

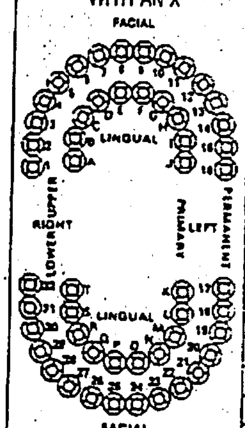
I AUTHORIZE RELEASE TO THE ABOVE PLAN ANY INFORMATION REQUIRED TO PROCESS MY CLAIM. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED.

Employee's Signature

TO BE COMPLETED BY THE DENTIST

DENTIST NAME		IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	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			
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

INDICATE MISSING TEETH WITH AN X



REMARKS

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

FOR OFFICE USE ONLY ☐ Usual & Customary

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED MO.	DAY	YR	PROCEDURE NUMBER	FEE	DEDUCTIBLE	75%	OTHERS	REMARK CODES

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST FOR THE SERVICES DESCRIBED ABOVE.

EMPLOYEE'S SIGNATURE DATE:

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

DENTIST'S SIGNATURE DATE:

TOTAL	
TOTAL COVERED	
TOTAL	
PLAN PAYS	
PATIENT PAYS	

* PLEASE NOTE: PRE-DETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT
This 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.