DENTAL CLAIM FORM

MASON COUNTY BOARD OF EDUCATION

RETURN THIS FORM TO:
AMERICAN BENEFIT CORPORATION
CLAIMS ADMINISTRATION
5160 US Route 60
Ona WV 25545-9507
(304) 525-0331

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

(Circle One) 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 Mason 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

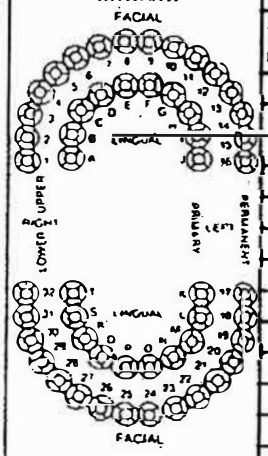
I hereby authorize payment directly to the named Dentist for the services described.

Employee's Signature

TO BE COMPLETED BY THE DENTIST

DENTIST NAME			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
ADDRESS			IS TREATMENT REBULT 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 PROTHESIS, 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?			DATE APPLIANCES PLACED (IF SERVICES ALREADY COMMENCED ENTER)	MOS. TREATMENT REMAINING

INDICATE MISSING TEETH WITH AN X



EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH 12
USE CHARTING SYSTEM SHOWN

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

REMARKS

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

DENTIST'S SIGNATURE DATE: