DENTAL CLAIM FORM

RETURN THIS FORM TO:

AMERICAN BENEFIT CORPORATION CLAIMS ADMINISTRATION

LEASE INDICATE	PLEASE INDICATE												A2 MATE Double 60 #									
☐ Pre-Treatment Esti	mate	(Servic	es in Exc	ess of \$	100)*						9200 US Route 60 • Ona, West Virginia 25545-9507											
☐ Actual Charges							······································								5,*****			-				
TO BE COMPLETED BY THE EMPLOYEE Employee's Name Married											Single Social Security N						urity Nu	mber				
Employee's Address	e's Address Number and Str								et					City	1	State	Zip C	ode				
Claim is For Self	Spo	ouse	Child		enden									C	epend	ent's Da	te of Bi	th				
f child is 19 years old is the person for who	or ol	der is (s claim	s)he ttend is being r	ling sch nade co	ool on vered	a full by ar	-time ba ny other	sis? grou	up qu	⊃ Y pla	es C n?) No	Yes		No			Mark of the second of the seco				
Name of School																						
Name of Group	ame of Group												Policy Number Address									
Name of Insurance C	Compa	any			<u>.</u>						D. C. C.			aim	Δ		***************************************					
I authorize release to photocopy of this au	o thoriza	ation m	ay be hor	ored.	1 any	intorn	nation re						- THY CR									
•						××××××××××××××××××××××××××××××××××	Empl	oyee	s's	Sig	ınatu	re	·				*					
TO BE COMPLETE	D BY	THE D	ENTIST							NO	YES	IF YES	, ENTER BR	EF D	ESCRIPTION	AND DATES						
DENTIST NAME DENTIST NAME S TREATM RESULT OF OCCUPATIC LILNESS OF									?							·						
ADDRESS IS RE										_												
CITY, STATE, ZIP CITY, STATE, ZIP ARE ANY SERVICES COVERED BY ANOTHER PLAN																						
DENTIST SOC. SEC. NO. OR TAX LO. NO. DENTIST LICENSE NO. DENTIST PHONE NO. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?										ļ —		(IF NO), REASON F	OR F	EPLACEMEN	ŋ		OF PRIOR ACEMENT				
PIRST VISIT DATE PL	RADIOGF MODELS I	APHS OR ENCLOSED	NO YES HOW MANY? IS TREATMENT FOR ORTHODONTICS?					-		af SER ALREA	SERMICES DATE APPLIANCES PLACED MOS. TREATMEN REMAININ ONLENCED THE TREATMENT ONLENCED THE TREATMENT OF THE											
					ENT DI AN	LISTING	<u> </u>		NO. 1	THRO	DUGH 32	ENTER			FOR							
INDICATE MISSING TEETH WITH AN X	1		EXAMINATION	TEM SHOWN	1 FROM TOOTH NO. 1 THRO HOWN							OFFICE USE ONLY 🗆 Usual & Customar										
FACIAL	TOOTH	SURFACE	IN	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.				SE	DATE SERVICE PERFORMED MO DAY YE		PROCEDURE NUMBER		RE FEE		DEDUCTIBLE 75%		OTHER% REMARK					
60000000000000000000000000000000000000	LETTER	SUAFACE		MATERIAL	S USED, E1	rc.		Mo	DAY	Ϋ́́Р				Π			l,	CODE				
\$ 600a		ļ			······································		······································	+						<u> </u>								
63 6 LINGUAL 10 140	<u> </u>	 						$\dagger \dagger$		1		,,,,,,,		-								
	<u> </u>	 						11								<u> </u>	ļ <u> </u>					
		-												-								
PERMANENT LE LE L								\perp						\vdash	<u> </u>			 				
HIGH REPORT THOUSEN								_				·		+-				 				
	}							-					 	-	 			1				
Char Car Findner (C) 18(7)	3	ļ						-						1								
\$ 5660 TO		ļ <u>.</u>						+														
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$								1								<u> </u>						
FACIAL		1											ļ	-		ļ		-				
REMARKS .		 						_	<u> </u>	\sqcup						1		-				
		1							<u></u>	_	тог	-A1	 		-			-				
I HEREBY AUTHORIZE PAYMENT OIL	RECTLY TO	THE BELOV	N NAMED DENTIST	FOR THE SE	AVICES DE	SCRIBED	ABOVE.					AL			-			+				
EMPLOYEE'S SIGNATURE DATE:												TOTAL	COVERED			T Z						
HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATES INDICATED.																						
DENTIST'S SIGNATURE DATE:												TOTAL										
* BI FASE NOTE: FRE-DETERMINA	TION OF B	ENEFITS DO	ES NOT GUARANT	TEE PAYMENT	_6_3_89 =	nic solim-1	e is subled to z	nodilical	lon b	ased		PLAN PAYS				••						
PLEASE NOTE: PRE-DETERMINA This estimate of benefits has been or	siculated ba	ased on curre	nt available benefits	and employee are completed	engipully. Tr Land claim i	us esiiकका a submitte	d for payment.				1	PATI	ENT PAYS									