WETZEL COUNTY BOARD OF EDUCATION
DENTAL PLAN

Return This Form To:

Wetzel County Board of Education
Dental Plan
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

(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 the Plan of any information required to process my claim. A photocopy of this authorization may be honored.	I hereby authorize payment directly to the named Dentist for the services described.
Employee's Signature	Employee's Signature

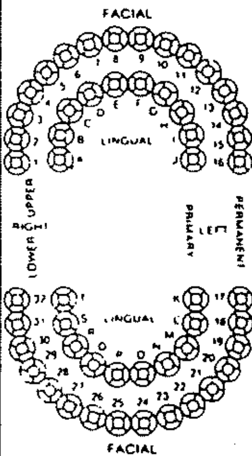
TO BE COMPLETED BY THE DENTIST

DENTIST NAME		
ADDRESS		
CITY, STATE, ZIP		
DENTIST SOC. SEC. NO. OR TAX I.D. NO.	DENTIST LICENSE NO.	DENTIST PHONE NO.

FIRST VISIT DATE	PLACE OF TREATMENT: OFFICE / HOSP. / ECF / OTHER	RADIOGRAPHS OR MODELS ENCLOSED	NO	YES	HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
IF PROTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) / DATE OF PRIOR PLACEMENT
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 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	

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

DENTIST'S SIGNATURE DATE: