DENTAL CLAIM FORM

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

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

For claims inquiries or coverage verification please call American Benefit Corporation: (800) 778-6118 or visit www.abcwv.com

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

Address

City, State, Zip

Dentist Soc. Sec. No. or Tax ID 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?

Question	No	Yes	
Is treatment result of occupational illness or injury?			If Yes, enter brief description and dates
Is treatment result of auto accident? Other Accident?			
Are any services covered by another plan?			
If prosthesis, 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

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

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
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.

VISION CLAIM FORM

For claims inquiries or coverage verification please call American Benefit Corporation: (800) 778-6118 or visit www.abcwv.com

RETURN THIS FORM TO:
Morgan Board of Education
Vision Plan
3150 US Route 60
Ona, WV 25545

TO BE COMPLETED BY EMPLOYEE

Name of Employee	Social Security Number XXX-XX-	____ Family ____ Single	Sex ____ Age ____	Phone No.

Address of Employee	Number & Street	City	State	Zip Code

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 ______________________

IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTIONS

Name of Dependent	_____ Married _____ Single Sex ___M___ F	Date of Birth	Relationship

Address of Dependent	Employer of Dependent

AUTHORIZATION

Employer	I authorize release to the above Plan any information required to process my claim. A photocopy of this authorization may be honored.
Date	______________ Employee's Signature
	I authorize payment directly to the provider of service ______________ Employee's Signature

TO BE COMPLETED BY DOCTOR

Patient's Name	Patient's Address
Was Prescription Written ____ Yes ____ No	Initial Glasses or Replacement?

If Replacement, Indicate Change in Dipter and Degree of Axis From Prior Prescription:

Are Lenses For Sunglasses? ____ Yes ____ No	Date of Prior Prescription

INDICATE CHARGES FOR SERVICES & MATERIALS

Examination: Date Fee Charged: $

Lenses Furnished: Date of Delivery
Indicate Type of Lenses Fee Charged: $______________

Single Vision ____________________ Bifocal ____________________

Trifocal ____________________ Lenticular ____________________ Date of Delivery ______________

Contacts ______________________________

Frames: Date of Delivery Fee Charged: $

Date: Total Cost To Patient: ______________ Fee Charged: $______________
State License Reg. No. ______________ Tax I.D. No. ______________

Print Signature: Doctor's Address:

Doctor's Signature Doctor's Phone

Please print then sign above your printed name.