DENTAL CLAIM FORM RETURN THIS FORM TO:

The second second	ite eatment Est Charges	imate (	Service	es in Ex	cess	of \$1	100)			9	200	U	an Benefit S Route 60 WV 25545		
To Be Completed Employee's Name		/ee				- 1737		Married			ingle	,	Social Secu XXX-X		nber
Employee's Addre	:52			Number at	nd Str	ect		8500000		City	,		State	-	p Code
Claim is For S If child is 19 years	Self Spou		hild anding sc	Dependent	nt's No	ame ne bas	is?	Yes	No		Dep	oende	nt's Date of Birth		
ls the person for w									Yes		14.7.2	No			
Name of School															
Name of Group						Polic	y Numbe	r							
Name of Insurance	Company						Add	dress							
authorize release photocopy of this s	to the above P authorization n	lan any in nay be ho	iformatio nored.	n required	to pro	occss n	ny claim.	A		Employ	me¹s S	ions	ure		
TO BE COMP	LETED BY	THE DE	ENTIST			-	-				-	16110		-	
TO BE COMPLETED BY THE DENTIST						Is treatme asset of occupation (Eness or	ng l	No Yes If Yes, eater brief description and dates							
<b>H</b>								Is treatme result of a accident?	at.						
ur, Tip							·	Are any at	svices						
ADE. See, No. or Tax ID No. Dentist License				No Dentist Phone No.				esother pl If prosther this lakis	theris, is 1f1			1186	If No, Reason for Replacement Date of Phoen		
is it Date	Pace of Free Office Hosp E			graphs or Enclosed	No	Yes	How Many?	placement Is treatment Orrhodons	at for			Aire	Date Appliances Pla rvices idy menced	oped .	Mos. Treats Remai
Indicate Missin		T	L		Exa	ininatios	and Treat		List in O			Ento	Through 32		<u>-</u>
With an 2								010							
WITH AN X		Tooth # or Letter	Surfac	Description of Service Including X-Rays, Prophylaxi Materials Used, etc.						Perfor	ete Service Performed P DAY YR		Procedure Number	Procedure Number I	
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A DELINOVAL															_
2. g.	\$ 1.9			<u> </u>							+				
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6	Ø 170														
rks FACIAL	90					-									
y authorize paymen	nt directly to the	below nam	ed Dentis	for the ser	vices d	escribe	d above			Total					
ee's Signature y certify that the se	rvices listed abo	ve have be	en perform	ed on the d	Dates in		:			Total	Covere	xď			
st's Signature Date:									Total						
ASE NOTE: Pre-Determination of Benefits does not guarantee payment stimate of benefits has been calculated based on current available benefits and employee eligibility. This									Plan Pays						
stimate of benefits to te is subject to modervices are complete	diffication based	upon rema	timing ben	cfits availa						Patier	t Pays				·