VISION CLAIM FORM

MONONGALIA COUNTY BOARD OF EDUCATION
DENTAL AND VISION BENEFIT PLAN

RETURN THIS FORM TO:
AMERICAN BENEFIT
3150 RT 60
ONA, WV 25545

TO BE COMPLETED BY EMPLOYEE

NAME OF EMPLOYEE – SOCIAL SECURITY NUMBER	☐ MARRIED ☐ SINGLE	SEX AGE	PHONE NO.

ADDRESS OF EMPLOYEE	NUMBER AND 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 MONONGALIA COUNTY BOARD OF EDUCATION VISION PLAN OF 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

SHOW TYPE OF CHECK MARK. FEE CHARGED: $

SINGLE VISION BIFOCAL

TRIFOCAL LENTICULAR DATE OF DELIVERY

CONTACTS

FRAMES: DATE OF DELIVERY FEE CHARGED: $

TOTAL COST TO PATIENT: FEE CHARGED: $

DATE: STATE LICENSE REG. NO. TAX I.D. NO.

DOCTOR'S SIGNATURE: DOCTOR'S ADDRESS:

DENTAL CLAIM FORM

MONONGALIA COUNTY BOARD OF EDUCATION
DENTAL AND VISION BENEFIT PLAN

RETURN THIS FORM TO:
AMERICAN BENEFIT
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
☐ 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 Monongalia 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

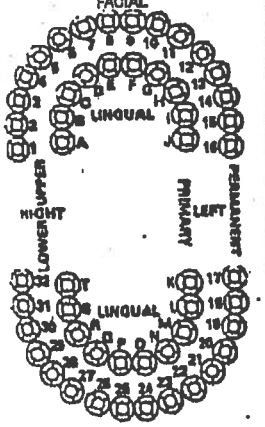
TO BE COMPLETED BY THE DENTIST

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

PATIENT'S NAME

EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH 32
USE CHARTING SYSTEM SHOWN

INDICATE MISSING TEETH WITH AN X



REMARKS:

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

*PLEASE NOTE: PRE-DETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT. This estimate 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 commenced and claim is submitted for payment.