Plan Name: | Return this form to the claims processor:

DENTAL CLAIM FORM

(CHECK ONE)

☐ Pre-treatment Estimate (Services in Excess of $200)*

☐ Actual Charges

WEST VIRGINIA ASSOCIATION OF COUNTIES DENTAL AND VISION BENEFIT PLAN

Plan Administrator and Sponsor:

WEST VIRGINIA ASSOCIATION OF COUNTIES

Benefit Assistance Corporation
PO Box 950, Hurricane, WV 25526
Phone: (304)562-1913
Electronic Claims Submission: www.eedi.net
Clearinghouse ID: 135221807

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME | SOCIAL SECURITY OR MEMBER ID NUMBER

EMPLOYEE ADDRESS | NUMBER AND STREET | CITY | STATE | ZIP CODE

☐ MARRIED ☐ SINGLE | SEX ☐ MALE ☐ FEMALE | DATE OF BIRTH | TELEPHONE NUMBER

ARE GROUP HEALTH INSURANCE BENEFITS PAYABLE FROM ANY OTHER SOURCE FOR THE EXPENSES SUBMITTED? ☐ YES ☐ NO

IF "YES": (A) INSURING ORGANIZATION:
(B) EMPLOYER:

IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTIONS

DEPENDENT NAME | RELATIONSHIP

DEPENDENT ADDRESS (IF DIFFERENT) | NUMBER AND STREET | CITY | STATE | ZIP CODE

☐ MARRIED ☐ SINGLE | SEX ☐ MALE ☐ FEMALE | DATE OF BIRTH | EMPLOYER OF DEPENDENT

AUTHORIZATION

I authorize release to West Virginia Association of Counties Dental and Vision Benefit Plan of any information required to process my claim. A photocopy of this authorization may be honored.

I authorize payment directly to the provider of service.

EMPLOYEE'S SIGNATURE | EMPLOYEE'S SIGNATURE

TO BE COMPLETED BY THE DENTIST

DENTIST NAME

ADDRESS

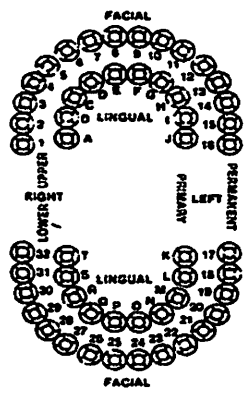
CITY, STATE, ZIP

DENTIST SS 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

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
IS TREATMENT RESULT OF AUTO ACCIDENT?			
IS TREATMENT RESULT OF 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



REMARKS:

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

FOR OFFICE USE ONLY ☐ USUAL & CUSTOMARY

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE	100%	80%	50%	REMARK CODE*

NOTES:

TOTAL		
TOTAL COVERED		
TOTAL		
PLAN PAYS		
PATIENT PAYS		

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 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.