DENTAL CLAIM REIMBURSEMENT

Side A to be completed by the member/group. Side B to be completed by the provider.

Please send completed Form and receipt of payment to:
The Health Plan, 1110 Main Street, Wheeling, WV 26003

Employee name: _____

HID #: _____ Group name/Group number: _____

Home address: _____

_____

Patient information: ☐ Self ☐ Spouse ☐ Child

Patient name: _____

☐ Male ☐ Female Date of birth: _____

Has there been or will there be a claim filed for worker's compensation benefits? ☐ Yes ☐ No

If an injury – state when, where and how the accident occurred.

_____

_____

Is any part of this expense paid or payable by any other insurance company? ☐ Yes ☐ No

If yes, name and address of carrier: _____

_____

This is to certify that the above information is correct.

Date: _____ Signature: _____

Dentist name: _____

Address: _____

City: _____ State: _____ Zip: _____

Dentist SSN or EIN: _____ Dentist Lic #: _____ Phone#: _____

	Yes	No	If yes, please enter description & dates
Occupational Injury?	☐	☐	
Accidental injury?	☐	☐	
Is treatment for orthodontics?	☐	☐	
If prosthesis, is this the initial placement?*	☐	☐	
			*If no, reason for replacement & date of prior placement

EXAMINATION AND TREATMENT RECORD – USE CHARTING SYSTEM BELOW					
Tooth # or Letter	Surfaces	Description of Services (Including x-rays, prophylaxis, materials used, etc.)	Date Service Performed	Procedure Number	Fee
Orthodontics: (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)				Total fee charged	
Date first appliance inserted				Payment by other plan	
Date last appliance removed				Balance	
Treatment period (# months)				Carrier pays	
Total fee				Patient pays	

I hereby certify that the procedures as indicated by date have been completed.

Dentist's signature: _____ Date: _____