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

DENTAL CLAIM FORM	DAVIS HEALTH SYSTEM, INC. HEALTH CARE PLAN	Benefit Assistance Corporation
(CHECK ONE) ☐ Pre-treatment Estimate (Services in Excess of $200)* ☐ Actual Charges	Plan Administrator and Sponsor: **DAVIS HEALTH SYSTEM, INC.**	PO Box 950, Hurricane, WV 25526 Phone: (304)562-1913 Electronic Claims Submission: www.eedi.net Clearinghouse ID: 135221807

TO BE COMPLETED BY EMPLOYEE

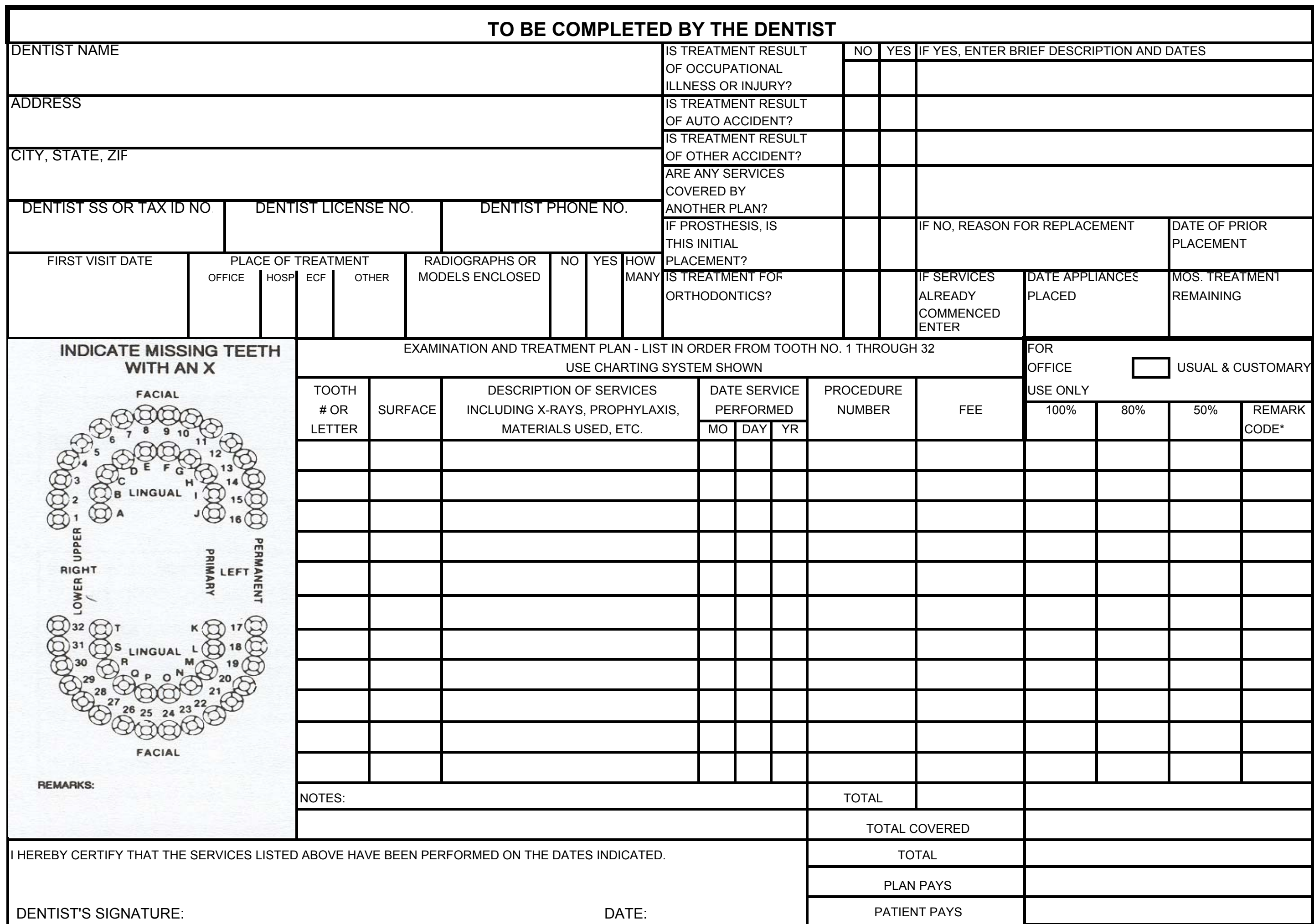
EMPLOYEE NAME			SOCIAL SECURITY OR MEMBER ID NUMBER	
EMPLOYEE ADDRESS	NUMBER AND STREET	CITY	STATE	ZIP CODE
☐ MARRIED ☐ SINGLE	SEX ☐ MALE ☐ FEMALE	DATE OF BIRTH	TELEPHONE NUMBER	
ARE GROUP HEALTH INSURANCE BENEFITS PAYABLE FROM ANY OTHER SOURCE FOR THE EXPENSES SUBMITTED? ☐ YES ☐ NO		IF "YES": (A) INSURING 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 Davis Health System, Inc. Health Care 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				NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
ADDRESS			IS TREATMENT RESULT OF AUTO ACCIDENT?			
CITY, STATE, ZIP			IS TREATMENT RESULT OF OTHER ACCIDENT?			
			ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SS OR TAX ID 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

INDICATE MISSING TEETH WITH AN X

FACIAL — UPPER — LINGUAL — RIGHT — LEFT — PRIMARY — PERMANENT — LOWER — LINGUAL — FACIAL

Upper: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16; A B C D E F G H I J

Lower: 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32; K L M N O P Q R S T

REMARKS:

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

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE	FOR OFFICE USE ONLY ☐ USUAL & CUSTOMARY 100%	80%	50%	REMARK CODE*
NOTES:						TOTAL					
						TOTAL COVERED					

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATES INDICATED.	TOTAL	
	PLAN PAYS	
DENTIST'S SIGNATURE: DATE:	PATIENT PAYS	

* **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.