DENTAL CLAIM FORM
AMERICAN BENEFIT CORPORATION

9200 US ROUTE 60 * ONA, WV 25545 * (304) 525-0331 * (304) 525-6005 FAX

EMPLOYEE SECTION

Employee Social Security No.	Employee Last Name	Employee First Name
Home Phone Number	Street Address	
City, State, Zip Code		Date of Birth
Employed By		

Are group health insurance benefits payable from any other source for the expenses submitted?

□ Yes □ No If "Yes," Name ____________________________ Policy No. ________________

Address ____

If claim is for **Dependent**, answer the following questions: Dependent Name_____________________

Dependent's Social Security No. _________________ Date of Birth ______________ □ Spouse □ Child

EMPLOYEE'S ASSIGNMENT

I authorize the release of information required to process my claim.

Date ________________________, 20______ Signed ____

(SIGNATURE OF EMPLOYEE)

I authorize payment directly to the provider of service.

Date ________________________, 20______ Signed ____

TO BE COMPLETED BY DENTIST

Dentist Name		Is Treatment Result of Occupational Illness or Injury? If Yes, Please Describe	
Address		Is Treatment Result of Auto Accident? Other Accident? If Yes, Please Describe	
City, State, Zip and Phone			
Dentist Tax ID No	Dentist License No	If Prothesis, Is This Initial Placement? Y N	If No, Reason for Placement and Date of Prior Placement
First Visit Date	Place of Treatment Off Hosp ECF Other	Radiographs or Models Enclosed? Y N	If Yes, How Many?
Is Treatment for Orthodontic?		Date Placed/Mos Treatment Remaining	

Examination and Treatment Plan

Tooth #	Surface	Description of Services				Date of Service	Procedure Number	Fee $
							Total	

I Hereby Certify That The Services Listed Above Have Been Performed On The Dates Indicated

Dentist's Signature: Date: