Mail completed forms to:
American Benefit Corp.
9200 US Route 60
Ona, WV 25545

Dental Expense Claim

To Be Completed by Employee

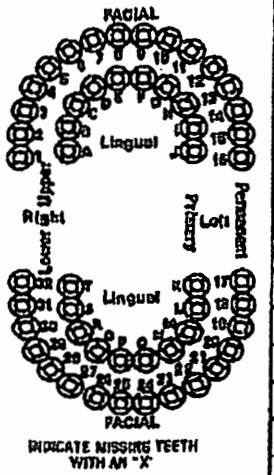
1. Patient First Name / Middle / Last	2. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	3. Sex ☐ Male ☐ Female	4. Married? ☐ Yes ☐ No	5. Patient Date of Birth Mo. / Day / Year	6. For Office Use
7. If Full-Time Student (Age 19 or Over) School / City / State	8. ID Number	9. If Disabled (Age 19 or Over) ☐ Yes ☐ No	10. Name of Group Dental Program		
11. Employee First Name / Middle / Last	12. Employee Date of Birth	13. Office Phone (Area Code)			
14. Employee Residence Mailing Address	15. City / State / ZIP				
16. Are other Family Members Employed? ☐ Yes ☐ No Name / Social Security / ID Number	17. Date of Birth	18. Name and Address of Employer for Item 16			
19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:) Dental Plan Name / Group No.	Name and Address of Carrier				

20. I Authorize Release of any Information Relating to this Claim.	21. I Certify that the Above Information is Correct.	22. I Authorize Payment Directly to the Below-Named Dentist.
(Signature of Patient or Signature of Authorized Representative if Minor) / Date	Employee Signature / Date	Employee Signature / Date
If Authorized Representative, Relationship to Minor		

To Be Completed by Dentist

23. Dentist Name	24. Mailing Address / City / State / ZIP			
25. Dentist Phone Number	26. Dentist License Number	27. Dentist SSN or T.I.N.	28. Provider Specialty Code	29. NPI (Treating Dentist)
30. NPI (Billing Entity, if different)	31. First Visit Date Current Series	32. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other		33. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many?
34. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		35. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		
36. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		37. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		
38. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement)				39. Date of Prior Replacement
40. Is Treatment for Orthodontics? ☐ Yes ☐ No	If Services Already Commenced, Enter Date Appliance Placed			Months of Treatment Remaining

Dentist's ☐ Pretreatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)**



41. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day /Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed.
*Signature of Dentist _____ Date Signed _____ Total Fee Actually Charged

43. Address where treatment was performed
Street _____ City _____ State _____ ZIP _____