The Health Plan
1110 Main Street
Wheeling, WV 26003
Telephone (740)695-3585
Toll Free 1-800-624-6961
www.healthplan.org

VISION BENEFIT CLAIM FORM

Please submit your billing along with this claim form to our Plan Administrator at:

Allied Services Division of The Health Plan
1110 Main Street
Wheeling, WV 26003
888-816-3096

EMPLOYER: OHIO COUNTY SCHOOLS

TYPE OR PRINT

PATIENT & INSURED (SUBSCRIBER) INFORMATION		
1. PATIENT'S NAME (First, Middle initial, Last Name)	2. PATIENTS DATE OF BIRTH	3. INSURED'S NAME (First, Middle initial, Last Name)
4. PATIENT'S ADDRESS (Street, City, State, Zip code)	5. PATIENT'S GENDER MALE FEMALE	6. INSURED'S I.D. NUMBER
	7. Patient's relationship to insured Self Spouse Child	8. INSURED'S GROUP NUMBER (OR GROUP NAME)
9. OTHER HEALTH INSURABCE COVERAGE–Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES NO B. AN AUTO ACCIDENT YES NO	11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any Medical information necessary to process this claim and request payment of Medicare Champus benefits either to myself or to the party who accepts assignment below SIGNED	DATE	13. I authorize payment of Medical Benefits to undersigned physician or supplier for services described below SIGNED

Did visual analysis indicate a change in prescription from the immediately preceding prescription? ☐ YES ☐ NO

SERVICES **CHARGES**

EXAM
Date of Service________________ $________

LENSES
Date of Service________________ $________

Type of Lenses
☐ Single
☐ Bifocal
☐ Trifocal

Was Lens
☐ Tinted
☐ Sunglasses and/or Safety Glasses
☐ Other__________

FRAMES
Date of Service________________ $________

CONTACTS
Date of Service________________ $________

Please advise reason for contacts (severe corneal astigmatism, severe corneal scarring, or patient prefers contacts etc.)________________

TOTAL $________

INDIVIDUAL PRACTIONERS-SS#			
ALL OTHERS-EMPLOYER IRS#			
Must be furnished under authority of law			

AMOUNT PAID $________

BALANCE DUE $________

Date Physician's Name Signature

Physician's SSN# or E.I.N# NPI # Phone #

Street Address City or Town State Zip Code

Employer Funded Plan

1110 MAIN STREET
WHEELING, WV 26003
(740)695-3585
800-624-6961

Dental Claim Form

☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

Ohio County Schools

PATIENT COVERAGE INFORMATION

1. Patient name First Middle Last
2. Relationship to employee?
3. Sex M F
4. Patient Birthday MM DD YY
5. If full time student School: City:
6. Employee name and mailing address
7. Employee SS#
8. Employee Birthdate
11. Is patient covered by another dental plan? ☐ yes ☐ no
12-a. Name and address of carrier(s)
12-b. Group no.(s) and/or policy no.(s)
13. Is spouse employed? ☐ yes ☐ no If yes complete 14 & 15
14-a. Spouse name (if different than patient's)
14-b. Spouse SS#
14-c. Spouse birthdate MM DD YY
15. Name & Address of Spouses employer

I hereby authorize any Physician, Hospital, Insurance Company, Employer or Organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim. A photostat of this authorization shall be valid as the original. This authorization shall extend to my spouce and dependents.

Signed (Patient, or parent if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named provider.

Signed (Insured Person) Date

BILLING DENTIST

16. Name of billing dentist or dental entity and specialty if other than dentistry
17. Address where payment should be remitted

City, State, Zip

18. Dentist Soc. Sec or T.I.N.
19. Dentist license #
20. Dentist phone #
21. First visit date in current series
22. Place of treatment Office Hosp. ECF Other
23. Radiographs or models enclosed? N Y How Many?

	No	Yes	If yes, enter a brief description and dates
24. Is treatment a result of occupational illness or injury?			
25. Is treatment a result of auto accident or other accident?			
26. Are removable full or partial dentures planned?			If yes, ☐ new--How old____ yrs. ☐ replacement
27. If prosthesis, is this initial placement?			(If no, reason for replacement) 28. Date of prior placement
28. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed / Mos. treatment remaining

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

RIGHT PRIMARY LEFT PERMANENT

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

Identify missing teeth with an "X"

30. Examination and treatment plan-- List in order from tooth #1 through tooth #32-- use charting system

Tooth # or Letter	Surface	Description Of Service (including x-rays, prophylaxis, materials used, ect.)	Date Service Performed M D Y	Procedure Number	Fee

31. Remarks for unusual services

32. Name of Referring Dentist if applicable:

I hereby certify that the procedures indicated by date have been completed and that the fees submitted are the actual fees that I have charged and intend to collect those for procedures.

Signed (Treating Dentist) License Number Date

"ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

DENTAL EXPENSE FORM--CLAIM INSTRUCTIONS

TO THE EMPLOYEE:

1. Complete items 1 through 15 on the claim form.
2. Sign the signature portions of the claim form as instructed.
3. Give the form to your dentist to file with the Plan.

NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR HANDBOOK ON THE SPECIFICS OF YOUR DENTAL COVERAGE FOR A DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND CO-INSURANCE INFORMATION, AND LIMITATIONS AND EXCLUSIONS OF THE PLAN.

TO THE DENTIST:

1. To bill your changes for this claim, check the box noted "STATEMENT OF ACTUAL SERVICES" on the top of the form. Complete all required information for items 16 through 32. Please be sure to provide the proper ADA code for each service provided in the space indicated and list an individual charge for each service shown. When the work is complete, please sign the form and mail to the address indicated below.

2. **PREDETERMINATION OF BENEFITS:** If treatment is not emergency in nature and is reasonably expected to exceed $300, a description of the treatment and an estimate of the charges must be filed prior to the commencement of the course of treatment. To obtain a predetermination of benefits, check the box marked"PRETREATMENT ESTIMATE" and complete items 15 through 31.

   The treatment plan should include supporting x-rays and/or other diagnostic records. For orthodontic procedures, the treatment plan must (1) provide a classification of malocclusion; (2) recommend and describe necessary treatment by orthodontic procedures; (3) estimate the duration over which treatment will be completed; (4) estimate the total charge for treatment; and (5) be accompanied by cephalometric x-rays, study models and other supporting evidence the claims administrator may require. Pre-treatment x-rays are required for gold restorations or crowns. They may also be requested for other services. X-rays will be reviewed and returned promptly.

   NOTE: THE TREATMENT PLAN AND SUPPORTING MATERIALS WILL BE REVIEWED BY PRACTICING DENTISTS. IF A LESS EXPENSIVE PROCEDURE IS FOUND TO BE EQUALLY SUITABLE FOR TREATMENT, THE BENEFIT AMOUNT FOR THAT ALTERNATIVE PROCEDURE WILL BE THE AMOUNT PAYABLE BY THE PLAN.

   THE COMPLETED FORM SHOULD BE SENT TO THE ADDRESS INDICATED BELOW. YOU WILL BE NOTIFIED OF THE BENEFITS PAYABLE FOR THIS COURSE OF TREATMENT.

3. Assigned benefits will be sent directly to you with an information copy of the transaction to the employee.

4. Any questions regarding the patient's dental coverage, payment, etc., should be directed to the Third Party Administrator indicated below.

PLAN ADMINISTERED BY:

THE ALLIED SERVICES DIVISION
THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC.
1110 MAIN STREET
WHEELING, WV 26003
TELEPHONE: (740) 695-3585
TOLL FREE: 1-888-816-3096