

CLAIM FOR MHI, Inc. DENTAL BENEFITS

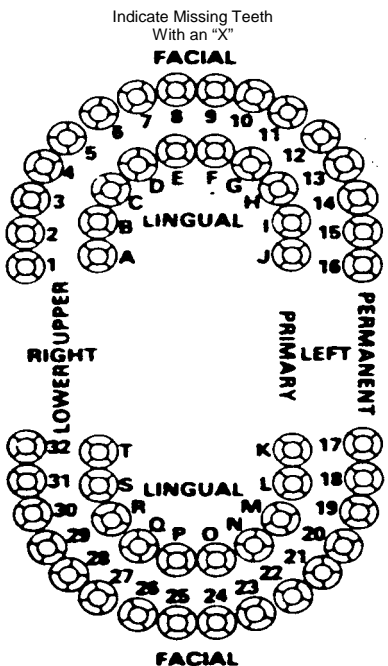
Mail to: Kanawha HealthCare Solutions, Inc.
 Post Office Box 1000
 Lancaster, SC 29721-1000
 Administered by: Kanawha HealthCare Solutions Inc.

EMPLOYEE STATEMENT

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE Self Spouse Child Other		3. SEX M F	4. PATIENT BIRTHDATE MO DAY YEAR		5. IF FULL TIME STUDENT School City	
6. EMPLOYEE NAME First Middle Last				7. EMPLOYEE SOCIAL SECURITY NO.		8. PERSONNEL LOCATION		
9. EMPLOYEE MAILING ADDRESS CITY, STATE, ZIP				10. POLICYHOLDER NAME AND ADDRESS				
11. GROUP NUMBER	12. ARE OTHER FAMILY MEMBERS EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No			13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12				
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No		DENTAL PLAN NAME		GROUP NO.		NAME AND ADDRESS OF CARRIER		
15. WAS TREATMETN REQUIRED BECAUSE OF AN INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, DID INJURY OCCUR WHILE AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No								
16. I authorize release of any information relating to the claim and I certify that the above information is correct. Signed: Patient (Parent if Minor) _____ Date _____				17. I authorize payments to be made directly to the below named Dentist. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. Employee Signature _____ Date _____				

IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS YOU KNOW ARE FALSE OR TO LEAVE OUT FACTS YOU KNOW ARE IMPORTANT.

DENTIST STATEMENT

18. DENTIST NAME		26. IS THREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? No Yes		IF YES, ENTER BRIEF DESCRIPTION AND DATES						
19. MAILING ADDRESS CITY, STATE, ZIP		27. IS TREATMENT RESULT OF AUTO ACCIDENT? 28. OTHER ACCIDENT?								
20. DENTIST Soc. Sec. or T.I.N.	21. DENTIST LICENSE NO.	22. DENTIST PHONE NO.		30. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT				
23. FIRST VISIT DATE CURRENT SERIES	24. PLACE OF TREATMENT Office Home Hos Other	25. RADIOGRAPHS YES NO HOW OR MODELS <input type="checkbox"/> <input type="checkbox"/> MANY? ENCLOSED?		31. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING				
DENTIST'S <input type="checkbox"/> Pre-Treatment Estimate <input type="checkbox"/> Statement of Actual Services		32. Examination and Treatment Plan – List in Order Tooth No. 1 through Tooth No. 32 Use Charting System Shown								
		Tooth # or Letter	Surfaces	DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis Materials Used, Etc.)		Date Service Performed No. Da. Yr.		ADA Procedure Number	Fee	For Carrier Use Only
33. REMARKS FOR UNUSUAL SERVICES							Total Fee Actually Charged			
I Hereby Certify That the Services Listed Above Will Be <input type="checkbox"/> Have Been <input type="checkbox"/> Performed										
Signed (Dentist) _____								Date _____		

INSTRUCTIONS FOR FILING A DENTAL CLAIM

An advantage of this Dental Insurance plan is the Pre-Determination of benefits provision. By having the dentist file your treatment plan, before the work is done, you and your dentist will know what benefits will be provided when the work is completed.

You may use the form in two ways:

AFTER dental work is completed – to apply for benefits

- or -

BEFORE dental work begins – to find out how much your dental plan may pay. This is called a pre-treatment estimate and should be requested if charges are expected to **EXCEED \$300**.

In either case, the entire **EMPLOYEE'S STATEMENT** portion of the form must be completed and signed.

NOTE

ITEM 7 – Always enter the **EMPLOYEE** social security number, even on a dependent's claim.

ITEM 16 – The **PATIENT** must sign. If the patient is a minor child, parent must sign.

ITEM 17 – The **EMPLOYEE** must sign if you want payments made directly to the dentist.

After you have completed the Employee's Statement, give this form to the dentist.

INSTRUCTIONS FOR DENTIST

1. The Plan pays benefits for covered dental services based on a percentage of the reasonable and customary charge for the service performed, but not more than the amounts actually charged. A separate charge is required for each service.
2. If the form is to be used for a "Pre-Treatment Estimate", please check the appropriate box and complete Items 18 through 33. For some services, supplementary pre-treatment information may also be required. The completed claim form, together with any required supplementary information, should be submitted to Kanawha prior to the commencement of the course of treatment.

Kanawha will review the claim (and any supplementary information submitted). You and Your patient will be notified of the benefits, provided by the plan, on a computer printed form. These benefits are subject to deductibles, if any, eligibility, prior payments and plan limits. You and your patient are free to pursue any treatment plan mutually agreed upon. Pre-Treatment Estimates are intended to avoid any misunderstanding among the patient, dentist and Kanawha, concerning benefits payable under the terms of the coverage. Estimates should not be requested for oral examination, cleanings, fluoride treatments, dental x-rays or emergency treatment. When the work is completed, enter the dates of services on the computer form, also any deviations from the treatment plan, sign the form as indicated, and submit for payment. **ALWAYS RETURN THE COMPUTER FORM.**

3. If treatment has been completed, please check the box noted "Statement of Actual Services" and complete Items 18 through 33. The claim form should be sent to Kanawha at the address shown below.
4. Generally, x-rays will not be required pre-operatively when the treatment plan involves only the use of Amalgam, Plastic, Silicate or Composite Restorations. However, diagnostic x-rays should be submitted for all other procedures including post treatment x-rays when endodontic treatment has been rendered.

REQUESTED X-RAYS WILL ALWAYS BE RETURNED PROMPTLY AND WILL BE USED ONLY FOR THE PURPOSE OF DETERMINING BENEFITS PAYABLE.

5. If the insured has so authorized, benefit payment will be made directly to you. (See Item 17)

MAIL COMPLETED FORM TO:
Kanawha HealthCare Solutions, Inc.
Group Dental Claims Office
P.O. Box 1000
Lancaster, SC 29721