

Online Claim Submission

Code: WCM

Employer: Wicomico County Public Schools

EmpID: 216800742

EmpName: WARD, AARON

Submitted: January 23, 2023

Batch: 29988919

Claim Total: \$45.94

Attachments: 6

Line	Service Date(s)	Type	Cost	Notes
1	1/17/2023	RX	\$6.74	Provider: Riverside Pharmacy. For whom: Timothy Ward. Prescription co-pay
2	1/6/2023	RX	\$5.00	Provider: CVS Specialty. For whom: Timothy Ward. Prescription co-pay
3	1/17/2023	DENTAL	\$34.20	Provider: Bryan Kaputa DDS. For whom: Aaron D Ward. Dental office visit co-pay

171/801 34.20 Ins Aaron Ward

DATE	FAMILY MEMBER	PROFESSIONAL SERVICE	CHARGE	CREDITS		NEW BALANCE	PREVIOUS BALANCE	NAME
				PAYMENTS	ADJ.			

You PAID this amount 171/801 34.20
This is a STATEMENT of your account to date

ATTENDING DENTIST'S STATEMENT

I. DIAGNOSTIC

- ☐ D0120 Periodic Oral Evaluation \$ 53
- ☐ D0140 Limited Oral Evaluation \$
- ☐ D0150 Comprehensive Oral Evaluation \$
- ☐ D0210 Intraral - Complete Series (Including Bitewings) \$ 16
- ☐ D0220 Intraoral - Periapical - First Film \$ 13
- ☐ D0230 Intraoral - Periapical - Each Add'l Film \$
- ☐ D0272 Bitewings - Two Films \$
- ☐ D0274 Bitewings - Four Films \$ 39
- ☐ D0330 Panoramic Film \$

II. PREVENTIVE

- ☐ D1110 Prophylaxis, Adult \$ 70
- ☐ D1120 Prophylaxis, Child \$
- ☐ D1208 Topical Application of Fluoride - Child \$
- ☐ D1204 Topical Application of Fluoride - Adult \$
- ☐ D1351 Sealant, Per Tooth \$

☐ _____ Teeth \$

III. RESTORATIVE

CODE TOOTH SURFACE

Resin Restorations

- ☐ D23 \$
- ☐ D23 \$
- ☐ D23 \$
- ☐ D23 \$
- ☐ D23 \$
- ☐ D23 \$
- ☐ D23 \$
- ☐ D23 \$

Crowns-Single Restorations Only

- ☐ D27 \$
- ☐ D27 \$
- ☐ D27 \$
- ☐ D27 \$

Other Restorative Services

- ☐ D2920 Recement Crown \$
- ☐ D2940 Sedative Filling \$
- ☐ D2950 Core Buildup, incl. Pins \$
- ☐ D2950 Core Buildup, incl. Pins \$
- ☐ D2954 Prefab. Post/Core \$
- ☐ D2954 Prefab. Post/Core \$
- ☐ D6057 Custom Abutment \$
- ☐ D6058 Abut. Supp. Porcelain Cr. \$

IV. ENDODONTICS

- ☐ D3110 Pulp Cap Direct (Excluding Final Restoration) \$
- ☐ D3120 Pulp Cap Indirect (Excluding Final Restoration) \$
- ☐ D3220 Therapeutic Pulpotomy (Excluding Final Restoration) \$
- ☐ Root canal therapy (including treatment plan, clinical procedures, and follow-up care)
- ☐ D3310 Anterior (Excluding Final Restoration) \$
- ☐ D3320 Bicuspid (Excluding Final Restoration) \$
- ☐ D3330 Molar (Excluding Final Restoration) \$
- ☐ Other endodontic procedures \$

V. PERIODONTICS

- ☐ D4210 Gingivectomy or Gingivoplasty 4+ Teeth/Quad. \$
- ☐ D4211 Gingivectomy or gingivoplasty 1-3 Teeth/Quad \$
- ☐ D4240 Gingival Flap Proc. incl. root planing, 4+ Teeth/Quad. \$
- ☐ D4241 Gingival Flap Proc. incl. root planing 1-3 Teeth Quad \$
- ☐ D4320 Provisional Splinting - Intracoronal \$
- ☐ D4341 Periodontal Scaling and root planing per Quadrant \$
- ☐ D4910 Periodontal maintenance procedures \$

VI. PROSTHODONTICS, REMOVABLE

Complete Dentures (Including routine post delivery care)

- ☐ D5110 Complete Upper \$
- ☐ D5120 Complete Lower \$
- ☐ D5130 Immediate Upper \$
- ☐ D5140 Immediate Lower \$

Partial Dentures (Including routine post delivery care)

- ☐ D52 Upper Partial \$
- ☐ D52 Lower Partial \$
- ☐ D54 Adjustment to Denture \$
- ☐ D55 Repairs to Complete Dentures \$
- ☐ D56 Repairs to Partial Dentures \$

VI. PROSTHODONTICS, REMOVABLE (Cont.)

Partial Dentures (Including routine post delivery care)

- ☐ D57 Denture Rebase \$
- ☐ D57 Denture Reline \$
- ☐ \$
- ☐ \$

IX. PROSTHODONTICS, FIXED

- | TOOTH | FEE |
|------------------------------|-----|
| Bridge - Pontics | |
| <input type="checkbox"/> D62 | \$ |
| <input type="checkbox"/> D62 | \$ |
| Bridge Retainers - Crowns | |
| <input type="checkbox"/> D67 | \$ |
| <input type="checkbox"/> D67 | \$ |
| <input type="checkbox"/> D67 | \$ |
| <input type="checkbox"/> D67 | \$ |

Other Fixed Prosthetic Services

- ☐ D69 \$
- ☐ D6930 Recement Bridge \$

X. ORAL SURGERY

- | TOOTH | FEE |
|---|-----|
| <input type="checkbox"/> D7140 Extraction, Erupted Tooth | \$ |
| <input type="checkbox"/> _____ | \$ |
| <input type="checkbox"/> _____ | \$ |
| <input type="checkbox"/> D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | \$ |

XII. ADJUNCTIVE GENERAL SERVICES

- ☐ D9940 Occlusal Guard \$
- ☐ D9972 External Bleaching \$
- ☐ Touch-up Whitening Kit \$

THIS IS A PRE-TREATMENT ESTIMATE

Circled fees are for services performed.

Today's Charges \$ Treatment Estimate \$

X-Rays Enclosed () Yes () No

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

Signed (Patient, or Parent if Minor)

Date

Signed (Insured Person)

Date

Dentist's Signature

Date

BRYAN J. KAPUTA D.D.S.

2315 E. NAYLOR MILL RD.
SALISBURY, MD 21804
410-543-0017

Tax I.D. #

Mastercard
AID: A000000041010
TVR: 00 00 00 80 00
CUSTOMER COPY

AMOUNT \$34.20

APPROVED

SALE

MID: 8870 Store: 4333 Term: 9801
Batch #: 904 REF#: 00000001
01/17/23 RRN: 301720410266
Trans ID: 017MWEADOKTF 15:43:36
APPR CODE: 58088P
MASTERCARD
*****5679
Contactless
DR KAPUTA DDS PA
2315 E NAYLOR MILL RD
SALISBURY, MD 21804



PO BOX 99778 | CHICAGO IL 60696

For help with billing questions, please call:
800-250-9631
Office Hours: Mon - Fri, 8:00AM to 8:00PM EST
☐ Check if address/insurance changes are on back

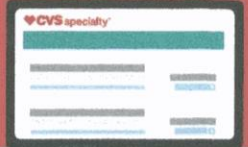
Addressee



TIMOTHY WARD
28867 ADKINS RD
DELMAR MD 21875-2533

CVSSpecialty.com/bills

For an easy way to pay,
visit us online.



Account Number
5704551

Due Date
Upon Receipt

Amount Due
\$5.00

Amount Paid
\$

Please make checks payable and remit to:



CVS/specialty
PO BOX 99778
CHICAGO IL 60696

0067026142000570455177800000005004

Please detach and return top portion with payment.

Account Number	Account Name	Statement Date	Due Date
5704551	WARD, TIMOTHY	01/06/2023	Upon Receipt

Date	Service Description	Charges	Payments/ Adjustments	Patient Balance
12/21/2022	RX #: 21782303-3 ; HUMIRA PEN (2/BOX) Exp Date: 03/19/2023 Refills Remaining: 0 Balance Due:	\$5.00	\$0.00	\$5.00 \$5.00
	Total Patient Balance Due:			\$5.00

MESSAGES

Thank you for choosing our Specialty Pharmacy. The customer balance due shown is your current responsibility. This balance may not reflect balances for orders not paid by your insurance.

Your statement design has changed!



Please see the back of this
document for details.



AMOUNT DUE:

\$5.00

If you have already submitted payment, please disregard this statement.

T1D101 - 37560696-004800-01/01-0-0-0

RX#:7456352R For: **WARD, TIMOTHY**
1/12/2023
28867 ADKINS RD
Delmar MD 21875 (410)219-1139
VITAMIN B12 1000MCG TAB 1000MCG
30 NDC:96295-0135-87
Dr. Malik, SUFYAN
Qty Left: 210.00



PICK UP
Cash: \$6.74

WARD

TIMOTHY

28867 ADKINS RD Delmar MD 21875
RX#:7456352R DOB: 10/28/1991
Dr. Malik, SUFYAN
Cash: \$6.74
VITAMIN B12 1000MCG TABLET 1000MCG



Shape:
Color Front:
Color Back:
ID Front:
ID Back:

FOR YOUR MEDICATION TO BE MOST
EFFECTIVE IF YOU HAVE ANY QUESTIONS

Your Medication

PLEASE TO PAY ABOVE TOTAL AMOUNT
RETURNING TO CARD ISSUER AGREEMENT

Merchant #: undefined
Date: Tue Jan 17 08:35:51 EST 2023
Trans#: 889956 Opt: HB
Auth#: XXXXX-XXXX-XXXX-7162
Visa
TOTAL: \$6.74

Due to potential contamination risks during COVID-19
pandemic and to ensure the continued safety of our
customers and employees effective 04/01/2020

Change: \$0.00
Amount Tendered: VISA XXXXX-XXXX-XXXX-7152 \$6.74
Total Amount Due: \$6.74
Subtotal: \$6.74
Discount: \$0.00
Tax: \$0.00



1 7456352-4
Subtotal: \$6.74
Discount: \$0.00
Tax: \$0.00
Total Amount Due: \$6.74
Amount Tendered: VISA XXXXX-XXXX-XXXX-7152 \$6.74
Change: \$0.00

Riverside Pharmacy

540 Riverside Dr. Salisbury MD, 21801
Tel: (410)742 1188
Date: Tue Jan 17 08:35:51 EST 2023
Trans: Sales Transaction POS Smt: 01
Trans#: 889956 Opt: HB

171/801 34.20 Ins Aaron Ward

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2315 E. NAYLOR MILL RD.
SALISBURY, MD 21804
410-543-0017

Signed (Patient, or Parent if Minor) _____

Date _____

Signed (Insured Person) _____

Date _____

Dentist's Signature _____

Date _____

Tax I.D. # _____

Mastercard
AID: A000000041010
TVR: 00 00 00 80 00
CUSTOMER COPY

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APPR CODE: 58088P
MASTERCARD
*****5679
Contactless
/

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SALISBURY, MD 21804



PO BOX 99778 | CHICAGO IL 60696

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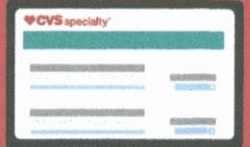
Addressee



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Subtotal: \$6.74
Discount: \$0.00
Tax: \$0.00



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Tel: (410)742 1188
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