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

DATE	FAMILY MEMBER	PROFFESSIONAL SERVICE	CHARGE	CREDITS: PAYMENTS	CREDITS: ADJ.	NEW BALANCE	PREVIOUS BALANCE	NAME
1/17/23	Aaron	exam,cbonXray	171	34.20		Ins.		Aaron Ward

171 | 80 | 34.20

You **PAID** this amount _____

This is a **STATEMENT** of your account to date

ATTENDING DENTIST'S STATEMENT

I. DIAGNOSTIC

		FEE
☐	D0120 Periodic Oral Evaluation	$ 53
☐	D0140 Limited Oral Evaluation	$
☐	D0150 Comprehensive Oral Evalution	$
☐	D0210 Intraral - Complete Series (Including Bitewings)	$
☐	D0220 Intraoral - Periapical - First Film	$ 16
☐	D0230 Intraoral - Periapical - Each Add'l Film	$ 13
☐	D0272 Bitewings - Two Films	$
☐	D0274 Bitewings - Four Films	$ 34
☐	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____	_____	_____	$

		Tooth	
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

		FEE
☐	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 Rrestoration)	$
☐	D3330 Molar (Excluding Final Restoration)	$
	Other endodontic procedures	
☐	____ _____	$

V. PERIODONTICS

☐	D4210 Gingivectomy or Gingivoplasty 4+ Teeth/Quad. _____ Quadrants	$
☐	D4211 Gingivectomy or gingivoplasty 1-3 Teeth/Quad _____ Quadrants	$
☐	D4240 Gingival Flap Proc. incl. root planing, 4+ Teeth/Quad.	$
☐	D4241 Gingival Plap 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

		FEE
	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.)

		FEE
	Partial Dentures (Including routine post delivery care)	
☐	D57__ Denture Rebase	$
☐	D57__ Denture Reline	$
☐	____ _____	$
☐	____ _____	$

IX. PROSTHODONTICS, FIXED

		TOOTH	FEE
	Bridge - Pontics		
☐	D62____	_____	$
☐	D62____	_____	$
	Bridge Retainers - Crowns		
☐	D67____	_____	$
☐	D67____	_____	$
☐	D67____	_____	$
☐	D67____	_____	$
	Other Fixed Prosthetic Services		
☐	D69____	_____	$
☐	D6930 Recement Bridge	_____	$

X. ORAL SURGERY

		TOOTH	
☐	D7140 Extraction, Erupted Tooth	_____	$
☐	____ _____	_____	$
☐	____ _____	_____	$
☐	____ _____	_____	$
☐	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.

▶ _____ _____

Signed (Patient, or Parent if Minor) Date

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

▶ _____ _____

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. # _____

FORM 083391 R/10/17 ITEM 8101

DR KAPUTA DDS PA
2315 E NAYLOR MILL RD
SALISBURY, MD 21804

SALE

MID: 8870 Store: 4333 Term: 9801
Batch #: 904 REF#: 00000001
01/17/23 RRN: 301720410266
Trans ID: 0117MWEA0OKTF 15:43:36
APPR CODE: 58088P
MASTERCARD
**********5679

Contactless
/

AMOUNT

$34.20

APPROVED

Mastercard
AID: A0000000041010
TVR: 00 00 00 80 00

CUSTOMER COPY

CVS specialty

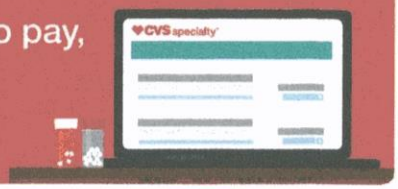
PO BOX 99778 | CHICAGO IL 60696

CVS-100

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

CVSspecialty.com/bills

For an easy way to pay, visit us online.



Account Number	Due Date	Amount Due	Amount Paid
5704551	Upon Receipt	$5.00	$

Addressee

Please make checks payable and remit to:

000044 - 4347

TIMOTHY WARD
28867 ADKINS RD
DELMAR MD 21875-2533

CVS/specialty
PO BOX 99778
CHICAGO IL 60696

00670261420005704551778000000005004

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	$5.00	$0.00	$5.00
	Balance Due:			**$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

THINK! RIVERSIDE PHARMACY FR9020203

540 Riverside Dr., Ste. 1
Salisbury, MD 21801
410.742.1188

RECEIPT

THINK! RIVERSIDE PHARMACY FR9020203

540 Riverside Dr., Ste. 1
Salisbury, MD 21801
410.742.1188

FILE

RX#:7456352R For: **WARD, TIMOTHY**
1/12/2023
28867 ADKINS RD
Delmar MD 21875 (410)219-1139

VITAMIN B12 1000MC TAB 1000MCG PICK UP
 # 30 NDC:96295-0135-87 **Cash: $6.74**
Dr. Malik, SUFYAN
Qty Left: 210.00

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

WARD **TIMOTHY**
1/12/2023
28867 ADKINS RD Delmar MD 21875
RX#:7456352R DOB: 10/28/199
Dr. Malik, SUFYAN **Bill: C**
Cash: $6.74 VITAMIN B12 1000MCG TABLET 1000MCG

IR YOUR MEDICATION TO BE MOST
ST IF YOU HAVE ANY QUESTIONS

Riverside Pharmacy

540 Riverside Dr Salisbury MD , 21601
Tel: (410)742 1188
Date: Tue Jan 17 08:35:51 EST 2023
Trans.:Sales Transaction POS Sn: 01
Trans#: 88996 **Opr.: HB**

1 7456352-4 $6.74

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

Total Amount Due: $6.74

Amount Tendered: $6.74
VISA $6.74
XXXX-XXXX-XXXX-7152

Change: $0.00

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

Merchant #:undefined
Date:Tue Jan 17 08:35:51 EST 2023
Trans# 88996 Opr.:HB
Visa
XXXX-XXXX-XXXX-7152
Auth#
TOTAL: $6.74

REE TO PAY ABOVE TOTAL AMOUNT
RDING TO CARD ISSUER AGREEMENT

Your Medication

I

DATE	FAMILY MEMBER	PROFFESSIONAL SERVICE	CHARGE	CREDITS: PAYMENTS	CREDITS: ADJ.	NEW BALANCE	PREVIOUS BALANCE	NAME
1/17/23	Aaron	exam,cbonXray	171	34.20		Ins.		Aaron Ward

171 | 80 | 34.20

You **PAID** this amount _____

This is a **STATEMENT** of your account to date

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		FEE
☐	D0120 Periodic Oral Evaluation	$ 53
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☐	D1110 Prophylaxis, Adult	$ 70
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☐	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____	_____	_____	$

		Tooth	
Other Restorative Services			
☐	D2920 Recement Crown	_____	$
☐	D2940 Sedative Filling	_____	$
☐	D2950 Core Buildup, incl. Pins	_____	$
☐	D2950 Core Buildup, incl. Pins	_____	$
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☐	____ _____		$

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		FEE
☐	D3110 Pulp Cap Direct (Excluding Final Restoration)	$
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☐	D3330 Molar (Excluding Final Restoration)	$
	Other endodontic procedures	
☐	____ _____	$

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☐	D4320 Provisional Splinting - Intracoronal	$
☐	D4341 Periodontal Scaling and root planing per Quadrant	$
☐	D4910 Periodontal maintenance procedures	$
☐	____ _____	$

VI. PROSTHODONTICS, REMOVABLE

		FEE
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☐	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.)

		FEE
	Partial Dentures (Including routine post delivery care)	
☐	D57__ Denture Rebase	$
☐	D57__ Denture Reline	$
☐	____ _____	$
☐	____ _____	$

IX. PROSTHODONTICS, FIXED

		TOOTH	FEE
	Bridge - Pontics		
☐	D62____	_____	$
☐	D62____	_____	$
	Bridge Retainers - Crowns		
☐	D67____	_____	$
☐	D67____	_____	$
☐	D67____	_____	$
☐	D67____	_____	$
	Other Fixed Prosthetic Services		
☐	D69____	_____	$
☐	D6930 Recement Bridge	_____	$

X. ORAL SURGERY

		TOOTH	
☐	D7140 Extraction, Erupted Tooth	_____	$
☐	____ _____	_____	$
☐	____ _____	_____	$
☐	____ _____	_____	$
☐	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.

▶ _____ _____

Signed (Patient, or Parent if Minor) Date

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

▶ _____ _____

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. # _____

FORM 083391 R/10/17 ITEM 8101

DR KAPUTA DDS PA
2315 E NAYLOR MILL RD
SALISBURY, MD 21804

SALE

MID: 8870 Store: 4333 Term: 9801
Batch #: 904 REF#: 00000001
01/17/23 RRN: 301720410266
Trans ID: 0117MWEA0OKTF 15:43:36
APPR CODE: 58088P
MASTERCARD
**********5679

Contactless
/

AMOUNT

$34.20

APPROVED

Mastercard
AID: A0000000041010
TVR: 00 00 00 80 00

CUSTOMER COPY

CVS specialty

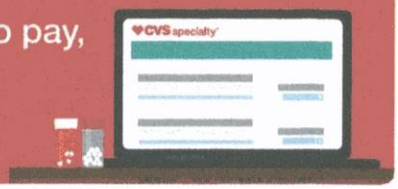
PO BOX 99778 | CHICAGO IL 60696

CVS-100

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

CVSspecialty.com/bills

For an easy way to pay, visit us online.



Account Number	Due Date	Amount Due	Amount Paid
5704551	Upon Receipt	$5.00	$

Addressee

Please make checks payable and remit to:

000044 - 4347

TIMOTHY WARD
28867 ADKINS RD
DELMAR MD 21875-2533

CVS/specialty
PO BOX 99778
CHICAGO IL 60696

00670261420005704551778000000005004

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	$5.00	$0.00	$5.00
	Balance Due:			**$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

THINK! RIVERSIDE PHARMACY FR9020203

540 Riverside Dr., Ste. 1
Salisbury, MD 21801
410.742.1188

RECEIPT

THINK! RIVERSIDE PHARMACY FR9020203

540 Riverside Dr., Ste. 1
Salisbury, MD 21801
410.742.1188

FILE

RX#:7456352R For: **WARD, TIMOTHY**
1/12/2023
28867 ADKINS RD
Delmar MD 21875 (410)219-1139

VITAMIN B12 1000MC TAB 1000MCG PICK UP
 # 30 NDC:96295-0135-87 **Cash: $6.74**
Dr. Malik, SUFYAN
Qty Left: 210.00

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

WARD **TIMOTHY**
1/12/2023
28867 ADKINS RD Delmar MD 21875
RX#:7456352R DOB: 10/28/199
Dr. Malik, SUFYAN **Bill: C**
Cash: $6.74 VITAMIN B12 1000MCG TABLET 1000MCG

IR YOUR MEDICATION TO BE MOST
ST IF YOU HAVE ANY QUESTIONS

Riverside Pharmacy

540 Riverside Dr Salisbury MD , 21601
Tel: (410)742 1188
Date: Tue Jan 17 08:35:51 EST 2023
Trans.:Sales Transaction POS Sn: 01
Trans#: 88996 **Opr.: HB**

1 7456352-4 $6.74

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

Total Amount Due: $6.74

Amount Tendered: $6.74
VISA $6.74
XXXX-XXXX-XXXX-7152

Change: $0.00

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

Merchant #:undefined
Date:Tue Jan 17 08:35:51 EST 2023
Trans# 88996 Opr.:HB
Visa
XXXX-XXXX-XXXX-7152
Auth#
TOTAL: $6.74

REE TO PAY ABOVE TOTAL AMOUNT
RDING TO CARD ISSUER AGREEMENT

Your Medication

I