

**Direct  
Assignment**  
**Treasure State Dental**  
**Your Plan. Your Way.**



Please check if you agree to accept MDA-Sponsored Direct Reimbursement plans:

**Direct Assignment**

**Yes!** I agree to accept assignment of benefits for Direct Assignment Plus plan patients. I understand that each claim will be reimbursed minus a withhold of \$12 per patient visit. I further understand that my practice is allowed and encouraged to collect \$10 of this withhold in the form of an additional \$10 copay at the time of the office visit.

Please check if you wish to decline this opportunity.

**No,** I will not accept assignment of benefits for Treasure State Direct Assignment plan patients.

***This is not a contract, but an expression of intent that may be changed by you at any time.  
All information will be kept strictly confidential.***

**Please fax, e-mail, or mail your response to:**

Ms. Sarah Harne  
Treasure State Dental  
1 N. Last Chance Gulch Suite 3  
Helena, MT 59601  
Fax (406) 442-1913  
sharne@mwbs-insurance.com

Practice Name: \_\_\_\_\_

Office Manager/Insurance Claim Processor (Contacts): \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

County: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Dentist (s): \_\_\_\_\_

\_\_\_\_\_

**Simply copy or tear off to complete and return to Treasure State Dental.**