# GUILFORD COUNTY SCHOOLS

## DENTAL REIMBURSEMENT REQUEST FORM

***(Use a Separate Form For Each Patient)***

EMPLOYEE NAME _____ EMPLOYEE SOC. SEC. NO. _____

EMPLOYEE HOME ADDRESS _____
Street City State Zip

PATIENT NAME _____ PATIENT BIRTHDATE _____ EMPLOYEE _____ SPOUSE _____ CHILD* _____ OTHER _____

*Is Child age 19 or older? Yes __ No __ If yes, is Child enrolled as a full-time student? Yes __ No __
If yes, name and address of accredited school or college: _____
_____

Are these expenses covered by another Dental Plan? Yes ___ No ___ Is the other Plan Primary (pays first)? Yes ___ No ___ If yes, attach a copy of other Plan's payment explanation.

Are these expenses covered by any Medical Plan? Yes ___ No ___

Is treatment result of Auto or Other Accident? Yes ___ No ___ If Yes, Give Date, Where and How Happened _____
_____

If Prosthesis, Is This Initial Placement? Yes ___ No ___ * If No, Give Date of Initial Placement _____

* Is Treatment for Orthodontics? Yes ___ No ___ If Yes, Give Date Appliance Was Placed _____
If this is the **Initial** filing of Orthodontic Expenses, we will need a copy of the contract agreement with the Orthodontist in order to determine if any expenses are eligible for consideration.

Attached are **PAID RECEIPTS** For: $_____ Of Dental Charges

NOTE: In order to promptly consider Dental Expenses, Paid Receipts(s) from the Dentist must be attached which indicate the following: (1) Who the services are for; (2) Date(s) the services were rendered; (3) Type(s) of treatment performed; and (4) Amount(s) and Date(s) of payment.

Charges and or payments must be filed within 12 months of date of service. If bill not paid in full, you can submit up to 5 payments for reimbursement. Each reimbursement must be a minimum of $100.00.

I certify that the charges for which I am requesting reimbursement have been paid in full or the acceptable minimum payment. If these expenses are covered by another dental plan, I understand coordination of benefits will apply. The Plan Sponsor or Plan Supervisor has my permission to verify any information relating to this claim with the appropriate dentist/orthodontist.

_____ _____
EMPLOYEE SIGNATURE DATE

**Mail Completed Form To:**

**PLAN SUPERVISOR**
**BENEFIT PLAN SERVICES, INC.**
**P.O. BOX 2793**
**HIGH POINT, NC 27261**
Telephone: (336) 889-2003

Revised 11/26/2007