Decatur County Board of Education
Dental Reimbursement Claim Form

Please submit this form with a paid cash receipt, charge card receipt, or a cancelled check attached. Reimbursements cannot and will not be made unless this form is completed and signed with proper documentation attached.

Claim Forms submitted to DCBOE by 4:30 Monday will be paid out on Thursday

Section I TO BE COMPLETED BY EMPLOYEE (please complete all information)

Employee's Name: _____ **Employee's SS#:**_____/_____/_____

Employee's Work Location: _____ **Work Phone:** _____-_____-_____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____ **Employee's Home Phone**:_____-_____-_____

Section II TO BE COMPLETED BY EMPLOYEE (please complete all information)

Patient's name: _____ **Patient's SS#**:_____/_____/_____

***Patient's date of birth (claim will not be processed without this)** _____/_____/_____
All dependents who are over 19 years old MUST be a full time student to receive dental benefits; forms will be returned unprocessed if proper documentation as a full-time student has not been received.

Patient's Relationship to Employee: **Self** ☐ **Spouse** ☐ **Dependent** ☐

Amount of Dental Expenses incurred: $_____ **Notes:** _____

EMPLOYEE STATEMENT

I certify that the charges for which I am requesting reimbursement have been paid in full and were made during the current reimbursement period. False receipts and forgery will be considered as a fraudulent act and will be grounds for dismissal. I also authorize my dentist to send the Decatur County Board of Education copies of records on any claim made if requested.

Employee's Signature: _____ **Date:**_____

HIPPA: This form is used to authorize, The DCBOE, and its agents, or employees, to use or disclose your protected Health Information (PHI) to the administrator, or employee's to administrate our DR Dental Plan. We will use your information for service, billing questions, claims, letters, and to provide your benefits to you. This authorization is at the request of the individual and will expire as of your termination of employment with the DCBOE. You have the right to revoke this authorization at any time by giving written notice of my revocation to the County Office. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation. I have had full opportunity to read and consider the contents of this authorization, and I understand that by signing this form, I am confirming my authorization of the use/or disclosure of my protected health information as described in this form.

Section III TO BE COMPLETED BY DENTIST

Date Service Performed	Dental Procedure Performed or attach statement of services rendered	Normal Charge	Discount	Total Amount Paid
		$	$	$
		$	$	$
		$	$	$

I certify that the dental procedures for the above named patient have been performed and were paid in full.

Dentist Signature: _____ **Date:** _____

Dentist Office Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____-_____-_____

Revised 1/2011