

Hamilton County Department of Education

Dental Plan Request for Reimbursement

Claims must be submitted within 180 calendar days of service date.

Please attach supporting documents behind this page.

PLEASE PRINT OR TYPE ALL ITEMS EXCEPT SIGNATURES

TO BE VERIFIED BY PROVIDER OF DENTAL SERVICES

Patient's Name _____ Date of Service _____ Services and Supplies Provided _____ _____ Provider Name and Address: (rubber stamp suggested) <u>Check Correct Statement</u> _____ Claim information has not been and will not be furnished to another carrier. _____ Claim information has been or will be furnished to another carrier. I certify that the services and supplies specified above were provided to the named patient on the date shown and for the fee shown. Signature of Provider or Facsimile Signature: _____	Patient's Social Security Number _____ Fee for Current Service: \$ _____ Other Insurance Paid \$ _____ Balance Paid: \$ _____
---	--

TO BE COMPLETED BY EMPLOYEE

Employee's Name	Social Security #
Mailing Address for Check:	
Work Location:	
This plan is secondary to our medical plan and any other dental plan. Tumors, excision of impacted teeth, and treatment of accidental injury to natural teeth (including their replacement) may be covered by your medical plan. For the current services, can you file a valid claim under our medical plan or another dental plan? _____ Attach a copy of insurance payment or denial.	
<u>Proof of Payment</u> <input type="checkbox"/> Cash Receipt <input type="checkbox"/> Cancelled Check <input type="checkbox"/> Credit Card Ticket	I certify that the information provided on this form is accurate to the best of my knowledge and belief. _____ Employee Signature

Send or bring **COMPLETED** form with proof of payment to:

Hamilton County Department of Education
 Benefits Department
 3074 Hickory Valley Rd.
 Chattanooga, TN 37421