**DENTAL REIMBURSEMENT REQUEST FORM**
(Please Complete a Separate from for Each Patient)

EMPLOYER NAME: _____

EMPLOYEE NAME:_____ EMPLOYEE SOC SEC. NO. :_____

EMPLOYEE HOME ADDRESS:_____
street city, state zip code

PATIENT NAME:_____ PATIENT BIRTH DATE:_____ EMPLOYEE ____ CHILD *____ SPOUSE ____ OTHER ____

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

_____

Are these expenses covered by another dental plan? Yes ___ No ___ If yes, is the other plan primary (pays first)? Yes ___ No ___ If yes, please attach a copy of the other plan's payment explanation.

Are these expenses covered by another medical plan? Yes ___ No ___

Is treatment result of auto or other accident? Yes ___ No ___ If yes, give date, where and how it happened:

_____

If Prosthesis, is this the initial placement? Yes ___ No ___ If Yes, give date of previous 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 and estimated treatment period from the orthodontist in order to determine if any expenses are eligible for consideration.

Attached are **PAID RECEIPTS** $_____ for dental expenses

**NOTE:** In order to promptly consider dental expenses, Paid Receipt(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 preformed; and (4) Amount(s) and date(s) of payment.

I certify that the expense(s) for which I am requesting reimbursement has been paid for the amount indicated above. If these expenses are covered by another dental plan, I understand coordination of benefits will apply. Benefit Plan Services, Inc. has my permission to verify any information relating to this claim with the appropriate dental/medical provider(s).

_____ _____
DATE EMPLOYEE/PATIENT SIGNATURE

**Mail Completed Form To:**

**PLAN SUPERVISOR**
**BENEFIT PLAN SERVICES, INC.**
POST OFFICE BOX 2793
HIGH POINT, NC 27261
Telephone (336) 889-2003
Website: www.bpstpa.com