DCUE Dental Reimbursement Fund Claim Form

6950 146th Street W. #114, Apple Valley, MN 55124 (952) 432-4033 *ISD 196 Teachers, Nurses & Counselors*

Complete ALL Sections in FULL- *see page 2 for Filing Information*

Section 1: Employee Information

Employee #1 **ID Number:**	Last Name	First	Date of Birth	School	COBRA YES / NO
Employee #2 **ID Number:**	Last Name	First	Date of Birth	School	COBRA YES / NO
☐ **Mark here if new address**	Address		City	State	Zip

Section 2: Dental OR Orthodontic Treatment Information

Name of Patient:
(one patient per claim form)

Relationship to Employee: □ Self □ Spouse □ Child
□ The dependent child listed is my natural, step, adopted or foster child.

Dental Only Date of Treatment: _____ *(one date of treatment per claim form)*

***Amount paid by Participant: _____

"Amount paid by participant" is the final charges you are responsible for after insurance payments, discounts and adjustments have been made.

Ortho Only Date of Payment(s): _____ *(multiple payments per claim form is acceptible)*

Amount of ortho Payment(s): _____

□ **1st ortho claim submission; copy of treatment plan is attached**

Name of Dental Provider/Office: _____

Dental Provider Phone: _____

Section 3: Coverage Verification Required

Choose One

☐ Patient **IS NOT covered under another dental or medical program**, other than DCUE Dental Reimbursement Fund, for the treatment claimed on this claim form.

☐ Patient **IS covered under another dental or medical program**, other than DCUE Dental Reimbursement Fund, for the treatment claimed on this claim form. **See Section 4- EOB Required

Section 4: Supporting Documentation Required

Required

☐ I have **attached** an **itemized statement** showing name of patient, date of treatment, specific treatment completed, charges, discounts and payments made; balancing my amount requested for reimbursement.

*****Required IF Insurance Applies*** **See Claim Form Filing Information

☐ I have **attached** the **Explanation of Benefits** from the primary insurance provider or other reimbursement plan for the treatment claimed on this claim form. Patient responsibility portion indicated on the EOB matches my payment(s) made.

I certify that the charges for which I am requesting reimbursement are not covered under any other dental or medical insurance, and that they have been paid and are accurate. In addition, I understand that my claim will be returned if ALL required documentation is not attached.

Signature of ISD 196 Employee _____ Date _____

DCUE Dental Reimbursement Fund
Claim Form Filing Information

Submit a **separate Claim Form for each individual.**
Submit a **separate Claim Form for each date of treatment.**

Claims MUST be filed within sixty (60) days of the treatment date, or MUST be filed within an additional thirty (30) days from the date of treatment, if your Primary Insurance Provider is other than DCUE Dental Reimbursement Fund. Late claims are assessed a 20% late penalty. Call to explain special circumstances. Claims filed after sixty (60) days past the end of the Plan Year (August 31) will be denied. Absolute deadline is October 31st.

If you have not paid your bill in full- Contact our office prior to submitting your claim to discuss your situation.

Send this Claim Form to DCUE Dental Reimbursement Fund either through school district interoffice mail or U.S. Mail
-DCUE Dental • 6950 146th Street West Suite 114 • Apple Valley MN 55124-

Reimbursement checks will be made payable to the district employee, and will be distributed through U.S. Mail to your address on file. If you have any changes in name(s), address or additions to family log into the Dental Members page, found at dcue.org, and edit your enrollment form during months August-May. June thru July notify DCUE Dental office by email.

If you have any questions regarding your claim, please call the DCUE Dental Reimbursement office at (952) 432-4033 or email dental@dcue.org.

Employee #1 – if you are the ISD 196 employee who has benefit coverage under the DCUE Dental Reimbursement Fund, your name and information goes here. Your identification number is required to process. *COBRA members should use their former Emp # or the ID # provided to them at the time of election. This field is for the account holder's information.*

Employee #2 – if both spouses are ISD 196 employees with benefit coverage under the DCUE/ISD 196 Collective Bargaining Agreement, the second employee's name and information must be provided to get the dual coverage. *Both employee numbers are required*.

COBRA – Answer yes to COBRA if you are not an active employee and paying a monthly premium for DCUE Dental coverage. If your status is Retired, LOA, Termination, Dependent Age 26, etc. you are considered COBRA status.

Address – list current address of employee. Mark the appropriate box if this is a new address.

Name of Patient – list the first name (and last name if different from Employee #1) of the patient for whom dental reimbursement is requested on this form. **Do NOT list more than one patient on a claim form.**

Relationship to Employee – indicate your relationship to the patient by checking the appropriate box.

Date of Treatment – date of dental visit for treatment requesting reimbursement on this claim form. **Do NOT list more than one date of treatment on a claim form.**

Amount Paid by Participant – is your claim amount. Amount needs to match charges minus any discounts, adjustments and primary insurance pymts. Payment(s) **MUST BALANCE** with charges, discounts and adjustments itemized. Proof of payment details needed are pymt type, how much, when it was paid. If other insurance is involved the amount(s) paid need to match patient responsibility amount on your EOB.

Date Ortho Payment(s) – date payment was actually made. **Multiple payments can be on one claim form.**
Amount of Ortho Payment(s) – amount of payment made or the total of multiple payments. Check box if this is the first ortho claim submitted for that individual; if yes, attach a copy of the treatment plan/financial agreement from orthodontist.

Name /Phone of Dental Provider/Office –information is necessary for processing and follow-up if needed.

A check mark- indicating whether you are covered under another dental or medical program is required for processing. **If you are covered by another insurance/program see below.

A complete itemized statement- showing name of patient, date of treatment, specific treatment completed, charges, and payments actually made must be attached. Discounts and/or adjustments given must be itemized on the statement.

****Required if Insurance Applies- If patient is covered by a primary insurance; such as Delta Dental, Blue Cross-Blue Shield, you must attach a copy of the Explanation of Benefits (EOB) from the insurance/other program provider. EOB is specific to date of treatment and individual requesting reimbursement for.**

Signature of ISD 196 Employee / Date – signature is required for processing. Specify the date this Claim Form was completed.