DCUE Dental Reimbursement Fund Claim Form

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

Instructions on Back

Section 1: Employee Information

Employee #1 **ID Number:**	Last Name	First	Date of Birth	School	COBRA
Employee #2 **ID Number:**	Last Name	First	Date of Birth	School	COBRA
☐ **Mark here if new address**	Address		City	State	Zip

Section 2: Dental OR Orthodontic Treatment Information

Name of Patient:

Relationship to Employee: □ Self □ Spouse □ Child

□ The dependent child listed is my natural, step, adopted or foster child.

Dental Only Date of Treatment: _____

*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): _____

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

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.

Section 4: Supporting Documentation Required

Required

☐ I have **attached** an **itemized statement** showing name of patient, date of treatment, specific treatment completed, charges, and payments made for which I am requesting 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.

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 paid on 80% of amount claimed. 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 the DCUE Dental Reimbursement Fund either through school district interoffice mail or through U.S. Mail.

DCUE Dental Reimbursement Fund
6950 146th Street West, #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 home address. Please notify the DCUE Dental Reimbursement Fund of any changes in names, addresses or additions to family.

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

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*.

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 each claim form.**

Relationship to Employee – specify if this Claim Form is filed for yourself, your spouse or your child and check box when appropriate.

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 each claim form.**
Amount Paid by Participant – actual payment made for treatment specified on itemized statement minus any expenses the plan does not cover (i.e. discounts, bleaching/whitening products or take-home products).

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 from orthodontist.

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

A check mark- indicating whether you are covered under another dental or medical program is required for processing.

A complete itemized statement- showing name of patient, date of treatment, specific treatment completed, charges, and payments actually made must be attached.

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

Signature of ISD 196 Employee / Date – specify the date this Claim Form was completed.