UNIVERSITY MEDICAL CENTER HEALTH SYSTEM

309 North Slide Road Lubbock, Texas 79416

DENTAL PROVIDER EXPENSE REIMBURSEMENT FORM

This section must be completed by employee.

Name of Employee:_____ Member ID #._____
Last First MI

Name of Patient:_____ Relationship: ☐Self ☐Spouse ☐Son ☐Daughter

If another insurance company pays as primary, please attach an Explanation of Benefits from that company.

I certify that the services for which I am authorizing reimbursement have been provided by the dental provider listed below. *I authorize the Dental Provider to release all information relating to this claim to my employer or agent.*

Signature:_____ Date: _____

Please mail check to:_____
Street City State Zip

Tier 1:
100% of the first $150.00 for covered dental expenses.

Tier 2:
80% over $ 150.00 up to $ 500.00 for covered dental expenses.

Tier 3:
50% over $ 500.00 up to an annual maximum reimbursement of $ 1,500 per covered individual per plan year for covered dental expenses.

This section must be completed by the Dental Provider.

Provider Name: _____ Tax ID No.: _____

Dental Services performed; please describe services using current CDT procedure codes:

Date of Service	*Procedure Code*	*Tooth Number*	*Description*

Note: If dental procedure is not described above, a claim form or receipt with procedure codes or a description of services must be attached to this form.

Amount to be reimbursed: $_____

I certify that the dental procedures for the above patient: ☐Have been completed ☐Are in progress

Dentist can submit claims to:

UMC Dental Reimbursement Plan
309 North Slide Road
Lubbock, Texas 79416
(806) 775-8793
(806) 761-0897 Fax

*Claims **must be filed** within **90 days** of services to be valid. Claims not received within 90 days will be rejected. If payment is not received within 30 days, please call The UMC Employee Plan at 806-775-8793*

DENTAL EXPENSE REIMBURSEMENT PROCEDURES

1. After services have been provided, attach a claim or receipt clearly indicating the services provided.

2. The dentist must complete and sign the appropriate area on the reimbursement form. Make sure services performed are described on the form.

3. Have the employee or member sign the form.

4. Mail your bill, reimbursement form and any proof of payment with description of services to:

UMC Dental Reimbursement Plan
309 North Slide Road
Lubbock, Texas 79416
(806) 775-8793
(806) 761-0897 Fax

5. Claims must be filed within ninety (90) days of the date the services were provided. Claims received after ninety (90) will not be reimbursed.