UNIVERSITY MEDICAL CENTER HEALTH SYSTEM

309 North Slide Road Lubbock, Texas 79416

EMPLOYEE DENTAL EXPENSE REIMBURSEMENT FORM

This section must be completed by employee.

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

Please mail check to:_____
Street City State Zip

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 charges for which I am requesting reimbursement have been paid in full. [An original paid receipt, original charge card receipt, or a copy of your canceled check (front and back) must be attached.] *I authorize the Dental Provider to release all information relating to this claim to my employer or agent.*

Signature:_____ Date: _____

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 paid receipt with procedure codes or a description of services must be attached to this form.

Amount to be Paid: $_____

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

And to the best of my knowledge the procedures were not a result of an on-the-job injury.

Signature:_____ Date: _____

Please submit forms 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. Take dental expense reimbursement form (available in the Human Resources Department) with you to your dental appointment.

2. After you have paid your dentist for services provided, request a receipt clearly indicating the amount paid.

3. Have the dentist complete and sign the appropriate area on the reimbursement form. Make sure services performed are described on the form. If the dentist does not complete this form, a paid receipt with a description of services is needed for proper processing of your claim.

4. Complete the employee area of the reimbursement form and sign the form indicating the questions were correctly answered.

5. Mail your bill, reimbursement form and 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

6. Claims must be filed within ninety (90) days of the date the claim was paid. Claims received after ninety (90) days from the claim payment will not be reimbursed.