DENTAL EXPENSE REIMBURSEMENT FORM

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THIS SECTION MUST BE COMPLETED BY THE EMPLOYEE

Name of Employee _____ Employee ID No._____
Last First MI

Name of Patient _____ Relationship ☐ self ☐ spouse ☐ son ☐ daughter

Is the patient covered by another dental insurance program? ☐ Yes ☐ No
If yes, give name of company _____and attach a copy of the payments by the other insurance company.

I certify that I have made the payment for the charges for which I am requesting reimbursement. (A paid receipt or canceled check must be attached. The receipt must be an original.) I authorize the dental provider to release all information relating to this claim to employer or agent.

_____
Signature of Employee **HOME CAMPUS/DEPARTMENT** **Date**

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THIS SECTION MUST BE COMPLETED BY THE DENTIST

Amount Paid $_____

Dental Procedure performed, if not on itemized receipt_____
_____

I certify that the dental procedures for the above patient ❑ have been completed ❑ are in progress

_____
Signature of Dentist **Date**

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Mail claims to: Lubbock I.S.D.
Risk Mgmt
1628 19th Street
Lubbock TX 79401

Fax Claims to: 1-806-766-1195

If you do not receive your reimbursement check within 30 days, please call the Risk Mgmt Office for the status at 219-0280.

Claims must be received by the Risk Mgmt Office within 90 days of payment.
Claims not received within 90 days of payment will be rejected.

This form may be photocopied or call 219-0280 and more will be mailed.
or

Print forms from the Internet by going to the LISD website: http://www.lubbockisd.org ➔Departments➔ Risk Management ➔Forms&Documents➔ Dental Expense Reimbursement Form

Revised 10/19

DENTAL EXPENSE REIMBURSEMENT PROCEDURES
LUBBOCK INDEPENDENT SCHOOL DISTRICT

- Take dental expense reimbursement form (available in the LISD Risk Management Office or on the Internet) with you to your dental appointment. Many local dental offices have forms available.

- After you have paid your dentist for services provided, request a receipt clearly indicating the amount paid and the work performed. Statements of amounts owed are not acceptable as proof of payment.

- Have the dentist complete and sign the appropriate area on the reimbursement form. (The dentist must complete this form for proper processing of your claim.)

- Complete the employee area of the reimbursement form and sign the form indicating the questions were correctly answered. A separate claim form must be completed for each claimant.

- Send your receipt or proof of payment and reimbursement form to the **LISD Risk Mgmt Office**. Claims may be faxed to 806-766-1195.

- **Claims must be filed within ninety (90) days of the date of payment. Claims received after ninety days of the claim payment date will not be reimbursed unless other insurance is involved.**