Littleton Public Schools

Direct Reimbursement Dental Claim Form

Your Plan Year is July 1 – June 30
Claims must be submitted within 6 months following the end of the above plan year.

Your Plan Pays:

High Plan Option	**Low Plan Option**
100% of the first $200 of expenses, then	100% of the first $200 of expenses, then
50% of the next $3,600 of expenses.	50% of the next $1,600 of expenses.
Annual Maximum Benefit - $2,000	Annual Maximum Benefit - $1,000
Orthodontia is included.	Orthodontia is NOT included.

(Please refer to the Orthodontic Treatment Plan form for instructions on Orthodontic reimbursement).

Employee Information: (MUST BE COMPLETED)

Name:	
Address: ☐ **Check if address is new.**	
Member ID #:	**Phone #:**
Patient's Name:	
Relationship:	**Patient's Date of Birth:**
If reimbursement is for a child ages 19 – 24, please provide proof of full time student status.	
Signature:	

Doctor Information: (MUST BE COMPLETED)

Doctor Tax ID #:(Required)	
Doctor Name:	
Doctor Address:	
Phone #:	**Total Cost of Treatment: $ __________**

Was the treatment for an accident or injury? ☐ **Yes** ☐ **No**

Are benefits to be paid to the doctor? ☐ **Yes** ☐ **No**

If yes, provider's W-9 form is required to meet I.R.S. regulations.
DO NOT SEND IN TREATMENT PRE-ESTIMATES OR X-RAYS

OTHER INSURANCE (Must be Completed)

Other Insurance Coverage ☐ **Yes** ☐ **No**

Insurance carrier Name:

The Direct Reimbursement Program is not a traditional insurance program; it is a reimbursement program. If you have other insurance coverage and are coordinating benefits, reimbursement from DRBP will be based on your out-of-pocket expense(s) **not** the total billed amount. The DRBP benefits schedule will apply.

You must attach an **ORIGINAL ITEMIZED BILL** to this claim form. If you have other dental insurance, and are coordinating benefits, please attach an **EXPLANATION OF BENEFITS (EOB)** from your primary insurance carrier. Mail this claim form, bill, and an EOB if applicable (coordination of benefits only) with your claim

YOU MUST ATTACH AN ORIGINAL ITEMIZED BILL to this form and mail to:
Direct Reimbursement Benefit Plans/P.O. Box 71549/Newnan, GA 30271
678-762-8842 or 1-888-745-3274
Fax- 770-683-1099

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- Reimbursement is made without regard to the procedure code. Please refer to your employee booklet for specific exclusions and details. COSMETIC CARE IS NEVER COVERED.
- You should expect your reimbursement check within ten business days.