

Sevier County Board of Education

Direct Reimbursement Claim Form

Your Plan Year is January 1 – December 31

Claims must be submitted by March 31st following the end of the above plan year.

Your Plan Pays:

OPTION I – Dental Only	OPTION II – Dental & Vision
100% of the first \$125 of eligible expenses, then the plan pays 50% of the next \$1,750 of eligible expenses to a maximum benefit of \$1,000 per person. Orthodontia Included.	100% of the first \$125 of eligible expenses, then the plan pays 50% of the next \$1,750 of eligible expenses to a maximum benefit of \$1,000 per person. Orthodontia Included. Includes a \$300 annual maximum per person for vision care (included in \$1,000 maximum). Vision care covers frames, lenses, contacts and eye exams.

Employee Information: (MUST BE COMPLETED)

Name:	
Address: <input type="checkbox"/> Check if address is new.	
Social Security #:	Phone #:
Patient's Name:	
Relationship:	Patient's Date of Birth:
If reimbursement is for a child ages 19 to 24, please provide proof of full time student status.	
Employee Signature:	

Doctor Information: (MUST BE COMPLETED)

Doctor Name:	
Doctor Address:	
Phone #:	Total Cost of Treatment: \$ _____
Was the treatment for an accidental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DO NOT SEND IN TREATMENT PRE-ESTIMATES OR X-RAYS	

YOU MUST ATTACH AN ORIGINAL ITEMIZED BILL to this form and mail to:

**Direct Reimbursement Benefit Plans/P.O. Box 71549, Newnan, GA 30271
Phone 888-745-3274 Or Fax to 770-683-1099**

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