



**DENTAL EXPENSE REIMBURSEMENT FORM**

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**THIS SECTION MUST BE COMPLETED BY THE EMPLOYEE**

Name of Employee \_\_\_\_\_ Social Security 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 \_\_\_\_\_ *Ortho*

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

**WENTZ ORTHODONTICS**

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_  
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**Submit your claim to: Lubbock I.S.D.  
Risk Mgmt  
1628 19th Street  
Lubbock TX 79401**

**If you do not receive your reimbursement check within 30 days, please call the Risk Mgmt Office for the status at 766-1109.**

**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 766-1109 and more will be mailed.  
or