Harrisburg R-VIII School District
DENTAL INSURANCE CLAIM FORM

Attach a copy of your itemized statement.

#1 About the Claimant

Employee Name (Print): _____

Patient Name (Print): _____ Age: _____

Relationship to Employee: _____

#2 About This Treatment

_____ Preventive
(examination, cleaning, etc.)

_____ Major Restorative
(crowns, bridges, etc.)

_____ Basic Restorative

_____ Other
(describe briefly) _____

#3 About This Claim

Name of Dentist/Specialist: _____

Total Cost of Treatment: $_____ Date of Service: _____

Is this claim a result of an accident at work? Yes _____ No _____

Is this claim covered by any other insurance coverage? Yes _____ No _____

Employee Signature: _____ Date: _____

Mail completed claim form and a copy of the itemized statement to:
Harrisburg R-VIII School District, % Lisa Hardin
1000 South Harris
Harrisburg, MO 65256
Telephone: (573) 875-5604 Fax: (573) 875-8877

CLAIMS:	Date	Bill Amount	Reimbursed Amount
	THIS CLAIM	_____	_____
	_____	_____	_____

Benefits Administered by: _____
Lisa Hardin, Central Office Secretary, Harrisburg R-VIII School District