Harrisburg R-VIII School District

Dental Insurance Claim Form

Part A: To be completed by insured.

About the Claimant ***One claim form per person.***

Employee Name (Print): _____

Patient Name (Print): _____ Age: _____

Relationship to Employee: _____

About This Treatment ***Check all that apply.***

_____ Preventive (examination, cleaning, etc.)

_____ Major Restorative (crowns, bridges, etc.)

_____ Basic Restorative

_____ Other (describe briefly) _____

About This Claim ***Attach a copy of your itemized statement.***

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, c/o Dawn Malone
1000 South Harris, Harrisburg, MO 65256
Telephone: (573) 875-5604 Fax: (573) 875-8877

Part B: To be completed by Harrisburg R-VIII Dental Coordinator.

Bill Date	Bill Amount	Reimbursed Amount	Check #	Reimbursed Date

Benefits Administered by: _____

Dawn Malone, District Bookkeeper, Harrisburg R-VIII School District