HOUSE STAFF BENEFITS PLAN

520 EIGHTH AVENUE, SUITE 1200, NEW YORK, NY 10018-4181

Phone: (212) 356-8180 Fax: (212) 356-8181 benefits@cirseiu.org http://www.cirseiu.org

SUPPLEMENTAL DENTAL BENEFIT CLAIM FORM

Eligibility**:** Effective 1/1/07, HSBP employees including eligible dependents.

Maximum reimbursement allowed:
Under the Dental Guard Preferred, the Maximum per person per benefit year is 20% of amount reimbursed by dental carrier, up to $1,000.
Under the Managed Dental Guard, the Maximum per person per benefit year is 20% of what the participant has paid in connection with receipt of covered dental services, up to $1,000.
In no way will the reimbursement be greater than what was paid out of pocket.

Claim Submission Rules:

- Section A must be completed in full by participant, patient or the parent, if a minor.
- If the participant or eligible dependent is enrolled in the Dental Guard Preferred, an Explanation of Benefits (EOB) must be attached to this claim form for processing.
- If the participant or eligible dependent is enrolled in the Managed Dental Guard, your assigned provider must complete Section B of this claim form with the exact date(s), diagnosis and procedure code(s) for which services were rendered. Only services that are covered by your dental carrier will be reimbursed by the Plan. Original receipts for eligible dental expenses must be submitted with this claim form.
- A separate claim form must be submitted per patient.
- All claims must be submitted to our office at the above-mentioned address within one year of the date of service. Claims submitted after one year will be denied.

SECTION A: TO BE COMPLETED BY PARTICIPANT OR PATIENT

Participant's Name: ______________________________ ______________________________
(Last Name) (First Name)

Social Security No.: ___________________ Hospital where employed: ___________________

Home Address: ____

___________________________ ______________________________ ____________________
(City) (State) (Zip code)

Contact phone number: _________________ E-mail address: ___________________________

Dental Plan Selection (Please check your current plan):
Managed Dental Guard Dental Guard Preferred

Patient's Name: _________________________________ _______________________________
(Last Name) (First Name)

Relationship to participant: __________________________

Patient's Signature or parent, if minor: _________________________ Date: ________________

(IMPORTANT: If you are on Managed Dental Guard, see side 2)

SUPPLEMENTAL DENTAL BENEFIT CLAIM FORM

SECTION B: TO BE COMPLETED BY ASSIGNED
MANAGED DENTAL GUARD PROVIDER

Complete Below and Attach Original receipts for eligible dental expenses

Date of Service	Diagnosis	Procedure Code	Co-payment Amount

Total Co-payment Amount $ ____________

Print Name of Dental Provider: ______________________________

Managed Dental Guard Provider Office No.: ________________________

Address: ________________________ ________________________ _______________ __________
(No. And Street) (City) (State) (Zip)

Telephone No.: _______________________

Dental Provider's Signature: _______________________________ Date: ___________________