HOUSE STAFF BENEFITS PLAN

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

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SUPPLEMENTAL DENTAL BENEFIT CLAIM FORM

Eligibility**:** HSBP employees including eligible dependents.

Maximum reimbursement allowed:

- Under the DentalGuard Preferred, the Maximum per person per benefit year is 20% of amount reimbursed by dental carrier, up to $1,000.
- Under the Managed DentalGuard, 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 DentalGuard 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 DentalGuard, 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. Receipts for eligible dental expenses must be submitted with this claim form (copies acceptable).
- A separate claim form must be submitted per patient.
- Claims must be submitted to our office via fax or mail (contact info in letterhead) within one year from date of service. *Do not email claims*. Claims submitted after one year will be denied.

SECTION A: TO BE COMPLETED BY PARTICIPANT OR PATIENT

Participant's Name:_____ _____ Social Security No.: _____
(Last Name) (First Name)

Hospital where employed: _____ E-mail address:_____

Home Address: _____ _____ _____ _____
(City) (State) (Zip code)

Contact phone number: _____ Type (home, mobile, etc.) _____

Dental Plan Selection (Please check your current plan):

☐ Managed DentalGuard ☐ DentalGuard Preferred

Patient's Name:_____ _____ Relationship to participant: _____
(Last Name) (First Name)

Patient's Signature or parent, if minor: _____ Date: _____

(IMPORTANT: If you are on Managed Dental Guard, complete page 2)

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SECTION B: TO BE COMPLETED BY ASSIGNED
MANAGED DENTALGUARD 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 code)

Telephone No.: _____

Dental Provider's Signature: _____ Date: _____

(10/20)