DCUE Dental Reimbursement Fund

6950 146th Street W. #114, Apple Valley, MN 55124 (952) 432-4033 ISD 196 Teachers, Nurses & Counselors

Claim Form (B): Oral Surgery/Wisdom Teeth Removal

Complete ALL Sections in FULL- *see page 2 for Filing Information*

Section 1: Employee Information

Employee #1 **ID Number:**	Last Name	First	Date of Birth	School	COBRA/Retired YES / NO
Employee #2 **ID Number:**	Last Name	First	Date of Birth	School	COBRA/Retired YES / NO
☐ **Mark here if new address**	Address		City	State	Zip

Section 2: Oral Surgery Treatment Information

Name of Patient: *(one patient per claim form)*

Relationship to Employee: □ Self □ Spouse □ Child

☐ The dependent child listed is my natural, step, adopted or foster child.

Oral Surgery Only Date of Treatment: _____ *(one date of treatment per claim form)*

*Amount paid by Participant: _____

"Amount paid by participant" is the final charges you are responsible for after insurance payments, discounts and adjustments have been made.

Section 3: Provider Information

Name of Oral Surgeon Provider/Office: _____

Oral Surgeon Provider Phone: _____

Oral surgeon provider MUST submit treatment charges to primary medical insurance first.

Supporting document required

Attach the final **itemized statement from the oral surgeon's office** showing name of patient, date of treatment, specific treatment completed, charges, insurance payments, discounts and your payments made; statement of account shows a zero balance.

Section 4: Medical Insurance

Circle one

YES / NO There are charges **covered under medical insurance** for the treatment claimed on this claim form.

If Yes, supporting document required

Attach the **Explanation of Benefits (EOB) or denial of coverage letter** from the **medical insurance** provider for the treatment claimed on this claim form. Patient responsibility portion indicated on the EOB matches my payment(s) made.

Section 5: Additional Dental Insurance Program

Circle one

YES / NO Patient **IS covered under another dental program** for the treatment claimed on this claim form.

If Yes, supporting document required

Attach the **Explanation of Benefits (EOB)** from the **dental insurance** provider for the treatment claimed on this claim form.

I certify that the amount in which I am requesting reimbursement is not covered and/or has not been submitted to any other dental or medical insurance, and that the amount has been paid and is accurate. In addition, I understand that my claim will be returned if ALL required documentation is not attached.

Signature of ISD 196 Employee _____ Date _____

March 15, 2025

DCUE Dental Reimbursement Fund
Oral Surgery/Wisdom Teeth Removal Claim Form Filing Information

Submit a **separate Claim Form for each individual by date of treatment.**

Claims MUST be filed within ninety (90) days of the treatment date with other insurance involved. Late claims are assessed a 20% late penalty. Call to explain special circumstances. Absolute deadline is October 31st for prior plan year claims. Plan year is September 1 – August 31.

If you have not paid your bill in full- Contact our office prior to submitting your claim to discuss your situation.

Send this Claim Form to DCUE Dental Reimbursement Fund either through school district interoffice mail or U.S. Mail
-DCUE Dental • 6950 146th Street West Suite 114 • Apple Valley MN 55124-

Reimbursement checks will be made payable to the district employee, and will be distributed through U.S. Mail to your address on file. If you have any changes in name(s), address or additions to family, log into the Dental Members page, found at dcue.org, and edit your enrollment form during months August-May. June thru July notify DCUE Dental office by email. You must be enrolled in the current plan year to receive reimbursement. Open Enrollment closes June 1 of each plan year.

If you have any questions regarding your claim, please call the DCUE Dental Reimbursement office at (952) 432-4033 or email dental@dcue.org.

Oral surgery claims MUST be processed and finalized by your medical insurance prior to submitting to DCUE Dental for reimbursement.

Section 2 – complete each field in full. Amount paid by participant is the amount you are requesting reimbursement for. This is your final out of pocket expense after insurance payments, adjustments, discounts and refunds have been applied. Payment(s) MUST BALANCE with charges, discounts and adjustments itemized on provider statement.

Section 3 – complete provider's business name and phone number. The oral surgeon must submit your treatment charges to your medical insurance first. The provider should also submit to your primary dental insurance, if you have one.
Required documentation from the provider needs to list name of patient, date of treatment, specific treatment completed, charges, insurance payments, discounts and your payment(s) made and if any refunds were given. This statement or multiple statements combined should have all the final numbers listed after insurance has processed and paid. Make sure your account balance is at zero.

It is necessary for DCUE Dental to have the final documentation from your provider to ensure your claim is being processed once for the accurate amount you are eligible for.

Section 4 – circle yes or no, whether your medical insurance is covering all or a portion of the treatment charges. Even if a portion or all of the treatment is not covered by medical insurance it is required to provide a copy of the Explanation of Benefits (EOB) stating what was or was not covered. If an EOB was not generated by the insurance co. then you must provide a denial of coverage letter from the medical insurance co.

Section 5 – circle yes or no, whether there is primary dental insurance or another dental benefit program involved in this claim. This is any dental coverage, other than DCUE Dental. If you have dental coverage through another program then an EOB from that benefit provider is required.

Signature of ISD 196 Employee – the District 196 employee must sign and date the claim form in which you are requesting reimbursement.
By signing this claim form you are certifying that the charges you are requesting reimbursement for have not and will not be covered by any other medical or dental provider.

If you are missing any required documentation your claim will be returned with a request for what is still needed in order to get reimbursed.