Katonah-Lewisboro School District

Dental Reimbursement Plan Request for Reimbursement

Instructions:

If you are submitting expenses for more than one calendar year, you must submit a separate form for each year.
Complete all information and be sure to sign the certification statement at the bottom of the form.
Keep copies of all documentation for your own records.
Send your claim form and itemized receipts to request reimbursement to:

The Preferred Group
P.O. Box 15136
Albany, NY 12212-5136
(518) 641-0321 or (866) 989-8997
Fax: (518) 641-0325
www.mytpgplan.com

Part 1: EMPLOYEE INFORMATION

Name: Last First Member ID:

Mailing Address: Street/PO Box City State Zip Code

Union Affiliation: □ **Administrators** □ **Support Staff** Please check if under 12 months of service □

Have you moved since your last request for disbursement? □ Yes □ No If YES, is this your new address? □ Yes □ No

Are you covered under another Dental Plan □ Yes □ No If YES, attach copy of other Plan EOB

Part 2: UN-REIMBURSED DENTAL EXPENSE ACCOUNT
IMPORTANT: SEE REVERSE SIDE FOR PROPER DOCUMENTATION
WHEN SUBMITTING REIMBURSEMENT REQUESTS

PATIENT'S NAME/AGE	RELATIONSHIP	DATES OF SERVICE FROM - TO	PROVIDER OF SERVICE	TYPE OF SERVICE	REIMBURSEMENT REQUEST
				Total Reimbursement Request: $	

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for which I am seeking reimbursement from the Dental Reimbursement Plan have been incurred by me, or by an individual who qualifies as my spouse or my dependent under the Katonah-Lewisboro School District Dental Reimbursement Plan. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other dental coverage, including a Health Savings Account (HSA).

Employee Signature_____ **Date**_____

Dental Expenses Documentation

Each expense you submit for reimbursement must be properly documented.

Along with this Claim Form you should submit:

- Itemized invoice
- Proof of payment – copy of your cancelled check, credit card receipt, or statement from provider that the invoice has been paid
- If another plan is primary, please provide a copy of explanation of benefit statement from insurance carrier or Plan

A bill from a provider must be on the provider's letterhead or billing form, and must include the following information:

- Name of patient
- Date of billing
- Date of Service
- Description of service
- Amount charged for service

Only itemized bills will be accepted.

"Balance Forward", "Amount Due" or similar wording, are not acceptable statements.

THE COMPLETED REIMBURSMENT REQUESTS FORMS SHOULD BE SUBMITTED TO:

The Preferred Group
P.O. BOX 15136
Albany, NY 12212-5136
Email Claims: Claims@tpgplans.com
TOLL FREE NUMBER 1-866-989-8997
Or
You can also submit claims through our secure site by going to; www.MyTPGPlan.com RESOURCES and SECURE FILE TRANSFER then send to CLAIMS recipient