**NEWTON COUNTY SCHOOL SYSTEM DENTAL, OPTICAL, & HEARING REIMBURSEMENT PLAN**
2019 PLAN YEAR PERIOD: JANUARY 1, 2019 – DECEMBER 31, 2019
***PLEASE NOTE ALL CLAIMS FOR 2019 MUST BE SUBMITTED BY 3/15/2020****

## ***SECTION I -TO BE COMPLETED BY EMPLOYEE****

Employee's Name: _____ Last 5 of SS#:_____

*Complete Address Section (**ONLY** **if it has changed since last claim was submitted**.)*

***NEW*** Home Address: _____

Phone:_____ Cell Phone: _____

To ensure reimbursement along with this form please be sure you have included the following:

_____ **YES**, I have included a statement of services.

_____ **YES**, I have included proof of payment. (i.e., cash receipt, charge card receipt, or cancelled check)

_____ **YES**, I have had my PROVIDER complete Section II of this document.

email address: _____

***Participants please be aware if you cannot answer YES to the previous 3 statements your claim WILL NOT be reimbursed until all proper documentation has been submitted. Allow at least 10 days for reimbursement.***

*I certify that the charges for which I am requesting reimbursement have been paid were made during the current reimbursement period, and are for any covered- employee/dependent of NCSS.* ***False receipts and forgery may result in ejection from the plan and probable grounds for immediate dismissal.*** *I also authorize my provider of services to send to the Administrator copies of my records on any claim made, (if requested.)*

Employee's Signature_____ Date_____

***Participants and Providers please be aware you may submit partial payments for services rendered.***

## *****SECTION II- TO BE COMPLETED BY PROVIDER (REQUIRED )*****

**Certain services and products are not eligible for reimbursement, such as: TEETH WHITENING, PRESCRIPTION SUNGLASSES (exception for bus drivers), CONTACT LENS CLEANING SOLUTION, etc.**

Patient's Name: _____ Patient's DOB_____

Relationship to Employee:_____ Date procedure performed: _____

Total amount charged: $_____

Amount to be reimbursed by insurance carrier: $_____

Net amount paid by patient: $_____

BALANCE DUE: $_____

Description of service: _____

I certify that the procedure for the above named patient has been performed and the above amount was paid by patient:

Provider's Signature: X_____Date_____

FAX CLAIMS TO: (706) 354-0999

Mail claims to: CANNON FINANCIAL STRATEGISTS

PLAN ADMINISTRATOR OF THE NCSS D/O/H PLAN
649-8 SOUTH MILLEDGE AVENUE
ATHENS, GA 30605

**EMAIL CLAIMS & QUESTIONS TO:**

**ncssdoh@cannonplanners.com**

CALL: 1-706-548-3422 OR 1-888-685-4524