

# Jefferson County Board of Education Dental/Vision Direct Reimbursement Claim Form

Your Plan Year is January 1 – December 31

Claims must be submitted by 3 months following the end of the above plan year.

**Your Plan Pays: Option I**

100% of the first \$125 of expenses,  
50% of the next \$1,750 of expenses.

**Your Plan Pays: Option II**

100% of the first \$125 of expenses,  
50% of the next \$1,750 of expenses.  
Vision Included, \$300 Maximum.

Note: Applies to  
Both Plans

Maximum annual benefit of \$1,000 per person.  
Orthodontics Included.

*(Please refer to the Orthodontic Treatment Plan form for instructions on Orthodontic reimbursement).*

**Employee Information: (MUST BE COMPLETED)**

<b>Name:</b>	
<b>Address:</b> <input type="checkbox"/> Check if address is new.	
<b>Employee ID #:</b>	<b>Phone #:</b>
<b>Patient's Name:</b>	
<b>Relationship:</b>	<b>Patient's Date of Birth:</b>
If reimbursement is for a child ages 19 – 24, please provide proof of full time student status.	
<b>Signature:</b>	

**Doctor Information: (MUST BE COMPLETED)**

<b>Doctor Name:</b>	
<b>Doctor Address:</b>	
<b>Phone #:</b>	<b>Total Cost of Treatment: \$ _____</b>
Was the treatment for an accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>DO NOT SEND IN TREATMENT PRE-ESTIMATES OR X-RAYS</b>	

**YOU MUST ATTACH AN ITEMIZED BILL to this form and mail to:**

**Direct Reimbursement Benefit Plans/Wells Fargo  
P.O. Box 71549/Newnan, GA 30271-1549  
Phone 888-745-3274 / Fax (770) 683-1099**

- ◆ Reimbursement is made without regard to the procedure code. Please refer to your employee booklet for specific exclusions and details. BLEACHING IS NEVER COVERED.
- ◆ You should expect your reimbursement check within ten business days.