JEFFERSON UNION HIGH SCHOOL DISTRICT
Administrative Offices

TO: Employees Participating in the Delta Dental Program

FROM: Tina Van Raaphorst, Associate Superintendent-Business Services

RE: **Request for Reimbursement of Dental Expenses**

Effective January 1, 2013, a change occurred in the annual limit of expenses covered by Delta Dental Insurance**.**

Covered procedures, which exceed the Delta Dental $1,700 per calendar year for Preferred Provider dentists and $1,500 per calendar for Out of PPO Network dentists, must be submitted directly to the district payroll department for payment. In order to process your request for reimbursement, please submit the following:

1. District claim form (attached).
2. Copy of Itemized bill from your dentist showing the amount of the covered procedure that exceeded my annual calendar year limit and proof of payment.
3. A copy of the Delta Dental "Your Dental Benefits Statement" form stating your claim was for eligible services but denied because you reached your annual maximum. If you do not receive the Delta Dental "Your Dental Benefits Statement" form, you can request a copy from member services at (866) 499-3001

All reimbursement claims must be received within 90 days of the end of the **calendar** year.

If you have any questions, please contact:

Certificated Staff: Michelle Sherwin(650) 550-7967
Classified Staff: Mike Brust (650) 550-7966

FAX (650) 550-7888

Attachment

JEFFERSON UNION HIGH SCHOOL DISTRICT
Dental Expenditure Reimbursement

TO: PAYROLL DEPARTMENT

FROM: _____
(Employee Name)

Send Reimbursement Check To: _____

(home address or school site: _____

RE: Request for Reimbursement of Dental Expenses

Please reimburse me for covered dental expenses which have exceeded the plan calendar year limit of:

$1,700 for Preferred Provider Organization (PPO) dentists or $1,500 for the out-of-PPO network dentists.

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Services were for : _____ OR _____
Self Name of covered Dependent/Relationship

Brief description of the covered procedure:

_____

_____

Employee Signature: _____

Date: _____

Claim Amount: _____

District Office Use Only

Approved by: _____

Date Approved: _____

Account Number: 01/0000/0/0000/7200/5815/090
Forms/Dental Reimbursement. 9-5-17