TOWN OF ATLANTIC BEACH
DENTAL CLAIM FORM

This section MUST be completed by employee:

Name of Employee ____
Last First Initial

Address ____
Street or PO Box City State Zip Code

Name of Patient ____

Patient's relationship to employee: Self ___ Spouse ___ Son ___ Daughter ___

If this claim is for a dependent with primary coverage from another dental plan, please attach a copy of the Explanation of Benefits.

Name of other company: ______________________________

AMOUNT OF DENTAL EXPENSES INCURRED: $____________________
DATE OF DENTAL SERVICE ______________________________________

I authorize the Town of Atlantic Beach, North Carolina to process this dental claim and to request information from the dental provider if/as necessary to process the claim. I also understand that any dental reimbursement will be made by the Town of Atlantic Beach to me and I am responsible for payment to the dentist. The information on this form is accurate and true to the best of my knowledge.

Signature of Employee ___________________________ Date ________________

PLEASE STAPLE YOUR PAID DENTAL RECEIPT FROM YOUR DENTIST TO THE BACK OF THIS REQUEST, OTHERWISE PAYMENT WILL NOT BE RENDERED! ALL CLAIMS MUST BE SUBMITTED TO THE FINANCE DEPT.

INSURANCE FRAUD IS A FELONY! Any person who knowingly and with intent to defraud or deceive the Town of Atlantic Beach, and files a statement of claim containing any materially false, incomplete or misleading information is subject to disciplinary action up to and including dismissal and may be liable for substantial civil penalties.