A. The dental benefits program is a self-funded program administered by Ameritas, Lincoln, Nebraska. (See Appendix B.)

1. Coverage paid at 100% of “ordinary and customary rates” with no deductible include:
   i. Two cleaning and examinations per calendar year.
   ii. One set of x-rays once a year.
2. The deductible on Type I and Type II procedures, as outlined in the policy, is $100.
3. Type I procedures are paid at 75%, and Type II procedures at 50%, after the deductible is met.
4. The maximum per person benefit in a calendar year is $1,500.
5. All claims must be submitted by using the Ameritas Group Dental Claim Form. (See sample.) Claim forms are available on the Employee Benefits website.

B. Assistance on claims and information is available by contacting the District’s Employee Benefits office at: (573) 214-3710.
**PART 1 – TO BE COMPLETED BY EMPLOYEE**

1. Patient’s full name (first, middle initial, last):

2. Patient’s birthdate (MM/DD/YY):

3. Relationship to employee:
   - self
   - spouse
   - child
   - other

4. Sex:
   - M
   - F

5. Employee’s full name (first, middle initial, last):

6. Employee’s identification number:

7. Employee’s mailing address (Street address or P.O. Box, City, State, ZIP):

8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER:
   - Is patient a full-time student? Yes No
   - If Yes, name and address of school:

9. Employer (Company) name and address:

10. Group number:

11. Division number:

12. Certificate number:

**QUESTIONS 11 AND 12 MUST BE COMPLETED WITH EACH CLAIM SUBMISSION**

11. Is patient covered by another dental plan? Yes No

12. Other employee/insured name:

   - Employee/insured identification number:
   - Date of birth (MM/DD/YY):
   - Relationship to patient:

13. I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of dental treatment. I certify these statements to be true and complete to the best of my knowledge.

   - Signature (patient, or parent if minor):
   - Date:

14. I hereby authorize payment directly to the below named dentist or group insurance benefits otherwise payable to me.

   - Signature (patient, or parent if minor):
   - Date:

**PART 2 – TO BE COMPLETED BY ATTENDING DENTIST**

Please provide Current Dental Terminology (CDT) American Dental Association procedure codes.

15. Dentist name and mailing address:

16. Specialist designation:

17. Phone #:

18. General anesthesia performed? Yes No

19. Date:

20. Date of last visit:

21. If Prosthesis, is this initial placement? Yes No

22. Is treatment for orthodontics? Yes No

23. This is a (please check one):
   - Statement of actual services
   - Pre-treatment estimate

**EXAMINATION AND TREATMENT RECORD**

<table>
<thead>
<tr>
<th>Tooth number, infinite or arch</th>
<th>Surfaces (including caps, prophylaxis, materials used, etc.)</th>
<th>CDT © ADA Procedure Code</th>
<th>Date Service Performed</th>
<th>Fee</th>
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25. Remarks for unusual services:

26. Total fee charged:

27. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

   - Signature (Dentist):
   - Date:

28. Address where treatment was performed:

**SAMPLE**