



Boys & Girls Club Workers Association

DENTAL & VISION EXPENSE REIMBURSEMENT CLAIM FORM

Follow These 3 Easy Steps to File Your Claim

1. Employee and Patient Information (Please print clearly & provide all information)
Name of Club (Employer)
Employee's Name (Last, First, Middle Initial)
Employee's Social Security Number:
Employee's Address
Employee's Date of Birth:
City State Zip Code
Employee's Marital Status:
Patient's Name (Last, First, Middle Initial)
Patient's Date of Birth:
Patient's Relationship to Employee:
Is patient covered under any other group dental insurance plan?
Is patient covered under any other group vision insurance plan?
2. Attach itemized Bills, Receipts, Statements (Containing all the following information)
A. Patient's name
B. Provider's name
C. Description of all services, supplies, items provided
D. The charge for each service or item
E. Date each service or item was provided
F. The amount you paid for the service or item
3. Certification & Authorization (Must be signed & dated by Employee.)
I hereby request reimbursement under the B&GCWA Group Dental & Vision Expense Reimbursement Plan for the expenses submitted with this claim. I certify that these expenses are not eligible for reimbursement from any other source. I further certify that the amounts indicated as paid by me are not owed to the Provider of Service.
I authorize the release of any information relating to these claims to CTI Administrators, Inc. for the purpose of evaluating and administering this claim.
I know it is a crime for any person to intentionally attempt to defraud or knowingly facilitate a fraud against an insurer by submitting an application or filing a claim containing a false or deceptive statement(s).
Employee Signature Date

Please send the completed claim form and appropriate bills to:

CTI ADMINISTRATORS -- Claims Department

100 Court Avenue - Suite 306, Des Moines, IA 50309-2295

1-800-245-8813