

For your convenience this form can be downloaded at www.BGCWA.com



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 Home Address		Employee's Date of Birth: ____ / ____ / ____	
City	State	Zip Code	Employee's Marital Status: [] Married [] Single [] Divorced
Patient's Name (Last, First, Middle Initial)		Patient's Date of Birth: ____ / ____ / ____	
Patient's Relationship to Employee: [] Self [] Spouse [] Child [] Stepchild If age 19+, is child/stepchild a full time student? [] Yes [] No If YES, provide name of school:			
Is patient covered under any other group <u>dental</u> insurance plan? [] Yes* [] No Is patient covered under any other group <u>vision</u> insurance plan? [] Yes* [] No * If YES, you must submit your claim to the other plan first and then provide documentation of its partial payment or denial with this claim.			
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 (include an itemized statement from your provider or you cancelled check)			
3. Certification & Authorization (Must be signed & dated by Employee.)			
I hereby request reimbursement under the BGCWA 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).			
			Date
		Employee Signature	

Please send the completed claim form and appropriate bills to:

CTI ADMINISTRATORS -- Claims Department

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

FAX to (515) 244-8650

For questions call toll free (800) 245-8813