Cleveland County
Direct Reimbursement Dental Plan Claim Form

Employee Section (Please Print):

Employee's Name_____ Social Security #_____

Contact #_____ Department_____

Claimant's Name_____ Social Security #_____

Claimant's Relationship to Employee SELF_____ SPOUSE_____ CHILD_____

Other Dental Coverage (Must Complete):

Is claimant covered under another dental plan other than Cleveland County?

YES_____ NO_____ If YES, name of other dental plan_____

IF another dental plan, please attach Explanation of Benefits (EOB) from dental carrier.

Signature:

Total amount of Dental Expenses $_____

Employee Signature_____ Date_____

Claims will be processed within two pay periods if proper information is received. The dental plan runs calendar year. Claims for the current year MUST be submitted to Payroll by January 10th of the following year. At year end, If EOB has not been received (if applicable), please submit claim and itemized statement by the January 10th deadline and submit EOB as soon as possible thereafter.

Submit:

Please submit this form, itemized statement of services rendered from dental office, and EOB from other dental carrier (if applicable) by mail, email, or fax.

FAX: (704) 484-4762

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MAIL: Cleveland County Payroll
Attn: Anita Bronowicz
PO Box 1210
Shelby, NC 28151-1210

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