Cleveland County
Direct Reimbursement Dental Plan Claim Form
for ORTHODONTIC Services

Employee Section (Please Print):

Employee's Name_____ Social Security #_____

Contact #_____ Department_____

Child's Name under 17 receiving orthodontic services_____

Child's Social Security #_____

Other Dental/Orthodontic Coverage (Must Complete):
Is claimant covered under another dental/orthodontic plan other than Cleveland County?

YES_____ NO_____ If YES, name of other plan_____
IF another plan, please attach Explanation of Benefits (EOB) from other carrier.

Signature:

Total amount of Orthodontic Expenses $_____ Month_____

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.

Note:

Please submit a claim for the time you pay your down payment and sign the contract with your orthodontist and attach a copy of the contract. Your monthly maintenance fees should be filed as they are paid, with receipts attached, along with EOB, if applicable, from other carrier.

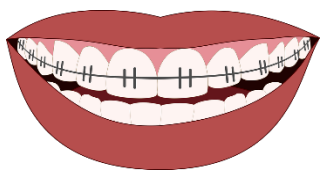
Submit:

Please submit this form, itemized statement or receipts from dental office, copy of contract if 1st time, and EOB from other dental carrier (if applicable) by mail, email, or fax.

FAX: (704) 484-4762

EMAIL: anita.bronowicz@clevelandcountync.gov

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



Revised: July 1, 2020