Elko County School District
Learning For All

For Assistance Please call: 833-951-1376
or contact online at www.myameriben.com

Vision/Dental Expense Reimbursement Request Form

Patient Information

1. Patient's Name (First, Middle Initial, Last)
2. Patient's Date of Birth ____/____/____
3. Patient's Address (Street, City, State, Zip Code)
4. Patient's Gender
   ☐ Male ☐ Female
5. Was condition related to:
   a. Patient's employment
      ☐ Yes ☐ No
      If yes, have you filed for Workers' Compensation?
      ☐ Yes ☐ No
   b. An auto accident
      ☐ Yes ☐ No
   c. Other type of accident
      ☐ Yes ☐ No
      If yes explain, ________________________
6. Patient's Relationship to Employee
   ☐ Self ☐ Spouse ☐ Child ☐ Other __________________
7. Nature of Request (Please provide details of the expense – name of patient, dental expense or vision expense. Use the back of this page if needed)
8. If condition was related to an accident and a police report was filed, please attach that report to this form.
9. Where was the service to the patient provided:
   ☐ Dental Office ☐ Physician Office ☐ Medical Equipment Supplier ☐ Pharmacy ☐ Other __________________________
10. Bills must be itemized.
    Each itemized bill must include:
    ☐ Name and address of provider ☐ Amount charged for each service ☐ Name of patient ☐ Diagnosis code ☐ Tax ID
    ☐ Service Provided ☐ Procedure code ☐ Date of service

Date of Service	Diagnosis Code	Procedure Code	Tax ID	Amount

Subscriber or Policyholder Information

11. Subscriber's Name (First, Middle Initial, Last)
12. Subscriber's ID Number
13. Subscriber's Address (Street, City, State, Zip Code)
14. Subscriber's Date of Birth ___/___/___
15. Subscriber's Group Number
16. Subscriber's Group Name
17. Is there other Dental ☐ or Vision ☐ Coverage (other than listed above)?
    ☐ No ☐ Yes (If yes, please provide the following information.)

Policyholder Name:______________________________ Policyholder ID Number:____________________ Group Number:________________

Effective Date of Policy: ____________________________

Name and address of the insurance company:____

____

____

Please sign here: ____ Date: ___/___/___

By signing above, I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse AmeriBen to the extent of any overpayment which is in excess of the amounts payable under the benefit plan administered by AmeriBen.

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law. Please follow the instructions on the back of this form to file this claim with AmeriBen.

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Procedure for Filing a Claim:

1. Complete the Claim Form on the opposite side.

    - Use one Claim Form per family member when submitting a claim.
    - Make sure you complete all questions.
    - Questions regarding other coverage you or your dependents are eligible for, must be answered.
    - Patient or parent (if patient is minor) must sign.

2. Attach all receipts/bills relating to claim.

    - Make sure all bills identify patient.
    - All bills should show treatment date, type of service (including CPT [procedure]/ICD-10 [diagnosis] codes) and amount of charges.

3. Mail claims to: AmeriBen
P.O. Box 7186
Boise, Idaho 83707

    or Fax: 208-955-1415

    or submit online: MyAmeriBen.com – log into your account and Submit a Document.