



# PSC CUNY Welfare Fund

61 Broadway, 15th Floor

New York, NY 10006

Phone: 212-354-5230 Fax: 212-354-5363

## Direct Dental Reimbursement Form

### For Plan 70 Retirees

File within 90 Days of Service

#### Member

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security Number \_\_\_\_\_

Employer - College (prior to retirement) \_\_\_\_\_

Member Status:  Retired  COBRA  Survivor

#### Patient

Relationship to Member  Self  Spouse / Domestic Partner  Dependent Child

*Complete the following only if the Patient is not the Member :*

Name of Patient \_\_\_\_\_

Other Dental Coverage: Name of Employer or Union \_\_\_\_\_ Contact \_\_\_\_\_

#### Amount Requested

\$ \_\_\_\_\_

Note the maximum annual reimbursement is \$300 *per family*.

#### Enclose an original bill from the dental provider with the following information;

- Retiree name and address
- Patient's name and relationship to Retiree
- Dental Service provided - including Procedure code
- Date of Service
- Amount due for services

I hereby certify that the above is true and accurate to the best of my knowledge.

Signature of Member \_\_\_\_\_ Date \_\_\_\_\_

Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_

OFFICE USE ONLY : Check # \_\_\_\_\_ Check Date \_\_\_\_\_ Amt. \_\_\_\_\_ Approved \_\_\_\_\_