AVONDALE SCHOOL DISTRICT
2940 Waukegan St.
AUBURN HILLS, MI 48326
248-537-6000

DENTAL REIMBURSEMENT REQUEST

Patient's Name_____Employee's Name_____

Street Address_____Patient's Relation_____

City and State_____Patient's Telephone_____

The employee must sign the following. I hereby authorize my doctor to supply and to release the information requested on this form to the Avondale School District Benefit Office.

_____Date_____
Employee Authorized Signature

Description of Service	**Date of Service**	**Fee Charged**	**Paid by Insurance**	**Patient Payment**
Total Fee Charged				
Total Paid By Insurance				
Patient's Total Payment (Receipt Required)				

1. The amount paid by the patient shall be only that amount **NOT COVERED** by other forms of insurance or other indemnity and actually **paid to your office by the patient**.

2. This completed form is to be returned to Avondale School District Benefit Office, 2940 Waukegan St., Auburn Hills, MI 48326, upon completion of treatment.

Please note the district reserves the right to review all claims. For questions, please call the benefit office of Avondale School District at 248-537-6010