

# CANISIUS COLLEGE DENTAL ASSISTANCE CLAIM FORM

Please submit a separate claim for each patient to the

**Controller's Office (HS 225A) Attention: Denise Rogers**

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**-Please Print-**

BANNER ID # \_\_\_\_\_

EMPLOYEE NAME \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

PATIENT DATE OF BIRTH \_\_\_\_\_

PATIENT'S RELATIONSHIP TO THE EMPLOYEE (CHECK ONE)

SELF \_\_\_\_\_

SPOUSE \_\_\_\_\_

DEPENDENT \_\_\_\_\_

(Eligible to age 23 if FT Student)

Dependent's Age: \_\_\_\_\_

Full-time Student: Yes \_\_\_ No \_\_\_

NAME OF DENTIST \_\_\_\_\_

DATE DENTAL WORKED PERFORMED \_\_\_\_\_

AMOUNT CLAIM SUBMITTED \_\_\_\_\_

Attach all paid receipts (credit card slip, cancelled check, or paid statement) to this form. If this expense is covered by any other dental insurance, copies of payment from primary insurance must be attached to this form and the following questions completed.

NAME OF INSURANCE COMPANY \_\_\_\_\_

NAME OF EMPLOYER COMPANY \_\_\_\_\_

TELEPHONE NUMBER OF EMPLOYER COMPANY \_\_\_\_\_

I certify that the charges for which I request reimbursement have been paid in full and not covered by any other dental insurance. Canisius College has my permission to verify any information relating to this claim with the appropriate Dentist.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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Business Office Use Only:

Approved by \_\_\_\_\_

Claim Number \_\_\_\_\_ Date Paid \_\_\_\_\_

Amount Paid \_\_\_\_\_ Check # \_\_\_\_\_

Voucher Number \_\_\_\_\_