DENTAL CLAIM FORM
KCDRB Form 11
LEOFF-I Dental Provider's Statement

(To be completed by dental care provider)
To request approval of reimbursement of dental expenses incurred or to seek pre-approval of future treatment, complete KCDRB Form 11 and attach an invoice for services completed or an estimate of planned work. If covered by dental insurance, invoice must be submitted to that insurance first. Only amounts not covered by insurance can be claimed. Submit all paperwork to LEOFF-1 employer for direct reimbursement. If necessary, the LEOFF-1 employer may choose to forward this claim to the King County Disability Retirement Board for final approval. If any questions please call the employer, or the King County Disability Retirement Board at 206-684-1556.

Patient's name: _____ Insurance: _____

Employer: _____ Insurance billed? ☐ Yes ☐ No

Employer Contact: _____ Telephone: _____

Dental care provider: _____

Provider's Street Address: _____ Telephone: _____

City: _____ State: _____ ZIP: _____

Service Date	ADA Code	Description	Amount
		Total Claimed	

(Invoice/statement may be attached.)

The services rendered by me and the medication, appliances, or other therapies that I prescribed are necessary services in view of the patient's diagnosis and condition. I hereby attest that the dental services rendered are solely for **non**-cosmetic reasons.

Signed: _____ Date: _____
Dental care provider

_____
Printed Name

The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board – your privacy over the Internet cannot be guaranteed.

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