



**THE MANAGED DENTAL PROGRAM CLAIM FORM
CARROLLTON FARMERS BRANCH INDEPENDENT SCHOOL DISTRICT**

NAME OF EMPLOYEE	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS (<input type="checkbox"/> CHECK IF NEW ADDRESS)	CITY	STATE ZIP CODE
THIS CLAIM IS FOR: <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	PATIENT'S NAME:	PATIENT'S DATE OF BIRTH:

YOUR RECEIPT FROM THE DENTIST OFFICE SHOULD INCLUDE: PATIENT NAME DATE OF SERVICE SERVICES PROVIDED AMOUNT OF CHARGES

SEND CLAIMS TO: QCD Of America Attn: Doris Hurtado 12222 Merit Drive Suite 1070 Dallas, Texas 75251 (800) 229-0304 (972) 726-0448 fax
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EMPLOYEE
SIGNATURE _____ **DATE** _____

THERE WILL BE A 100% CLAIM REIMBURSEMENT FOR THE FOLLOWING
PREVENTIVE SERVICES:

<u>PROCEDURE NUMBER</u>	<u>PROCEDURE NAME</u>
1110	Prophylaxis - Adult
1120	Prophylaxis - Child
1203	Fluoride Application
1351	Sealants
0220	Bitewing X-ray - Single
0272	Bitewing X-ray - Two
0273	Bitewing X-ray - Four