Health New England

One Monarch Place, Suite 1500
Springfield, MA 01144-1500
healthnewengland.org

City of Westfield
Pediatric Preventive Dental Form

City of Westfield (Health New England group number S03048) will reimburse for pediatric preventive dental services for covered dependents under age 12 including:

- Oral exam - initial exam for a new patient, once every 6 months (D0120); once per Dentist (D0150)
- Cleanings – once every 6 months (D1120)
- Fluoride Treatment – once every 6 months (D1208)
- Bitewing x-rays – one set every 6 months (D0272, D0274)
- Complete x-ray series or panoramic film – once every 60 months (D0330, D0210)
- Single x-rays – as required (D0220, D0230, D0240, D0270)

Reimbursement requirements:

- The employee must be actively at work at the time the expense was incurred.
- Employees can submit forms twice in each calendar year.
- Itemized receipts will not be returned. Health New England will accept copies of receipts.

Employees will not be reimbursed for:

- Restorative services (inlay, crown, bridge, partial or complete denture)
- Extractions
- Oral surgery
- Prosthodontics
- Prosthetics
- Orthodontics
- Services covered by a comprehensive dental plan

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Employee Information		
Last Name:	First Name:	
Street Address:		
City:	State:	Zip:
Health New England ID #:		
Telephone #:		
Dependent Information		
Last Name:	First Name:	
Date of birth:	ID#:	
All reimbursements will be sent to the Subscriber's address currently on file with Health New England		
Pediatric Dental Reimbursement Information		
Dental Provider Name	Dental Provider Address/Phone#	

Proof of Service:
❑ An itemized bill from the dental provider of service, including date of service, description of service, CPT code

Proof of Payment through one of the following:
❑ Front and back of a cancelled check written to the dental provider or bank-encoded front of the check
❑ A credit card statement or receipt
Itemized statements and/or invoices do not count as proof of payment

Read instructions before completing and signing this form.

I authorize the release of any medical or other information necessary to process this claim. I attest that the above information is true and accurate, and that services were received and paid for in the amount requested as indicated above.

I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims.

Employee's signature: _____ Date: _____

Please submit this form and all documentation to:
Health New England - Member Reimbursements, One Monarch Place, Suite 1500, Springfield, MA 01144-1500
Please allow 4-6 weeks for processing.

NOTE: Reimbursement requests must be received by Health New England no later than March 31st for the prior calendar year.