Dental Expense Reimbursement Form

Employee Information

Full Name:

Employee ID:

Department:

Email Address:

Patient Information

Patient Name:

Relationship to Employee:

Dental Expense Details

Date of Service:

Service Provider:

Description of Service:

Amount Claimed ($):

Declaration

☐ I hereby certify that the information provided is accurate and the claim is made in accordance with company policy.

Employee Signature:

Date:

Submit