July 1, 2024

AVONDALE SCHOOL DISTRICT 2024-2025 DENTAL REIMBURSEMENT SCHEDULE

To: AVPE Members

For your dental claim to be processed, the most recent reimbursement form must be completely filled out with a paid receipt for services attached to the back (one form for each family member). If you are submitting claims for more than one family member, but all payments are on the same receipt, please make a copy of the receipt and attach to each claim form.

All Requests for reimbursement from July 1 through June 30th of the year must be received no later than July 10. The First two Hundred dollars ($200.00) of eligible dental/optical expense for each covered individual (Coverage under this section is Limited to Husband, wife, and dependent children.)

All other dental/optical expenses in excess of two hundred dollars ($200.00) incurred during the fiscal period will be reimbursed on a prorated basis if necessary and paid on an August payroll.

Two (2) cleanings are allowed per year. One complete set of x-rays is allowed per year. Limit of one hundred dollars ($100.00) toward orthodontics. Bleaching, implants and veneers are not covered. One optical exam is permitted. One complete set of glasses with lenses (limit of $100 toward the frame) OR Two hundred dollars ($200.00) towards contacts. The amount of reimbursement under this section is limited to fifteen hundred dollars ($1500.00) per employee family.

Forms due to HR by:	Check Issued:
Friday, September 6, 2024	Friday, September 27, 2024
Friday, October 4, 2024	Friday, October 25, 2024
Friday, November 1, 2024	Friday, November 22, 2024
Friday, December 6, 2024	Friday, December 20, 2024
Friday, January 3, 2025	Friday, January 17, 2025
Monday, February 3, 2025	Friday, February 28, 2025
Friday, March 7, 2025	Friday, March 28, 2025
Friday, April 4, 2025	Friday, April 25, 2025
Friday, May 2, 2025	Friday, May 23, 2025
Friday, June 6, 2025	Friday, June 20, 2025
FINAL PAYOUT FOR 2024-2025 SCHOOL YEAR FOR SERVICES AND PAYMENT BEFORE July 1, 2025	
Monday, July 10, 2025	August 15, 2025

Please submit all claims to Annamaria Wyman in the Human Resources office

Mail to: 2940 Waukegan Street, Auburn Hills, MI 48326

Scan and Email to: dentalclaims@avondaleschools.org

Please do not fax

Dental/ Optical Reimbursement Request

- An itemized paid receipt must accompany all reimbursement requests. Requests submitted without a paid receipt will not be accepted.
- The District shall establish a Dental/Optical Fund in the amount of 20,000. Any money not expended during a given year will be added to the funds available for the following year.
- All Requests for reimbursement from July 1 through June 30th of the year must be received no later than July 10. The First two Hundred dollars ($200.00) of eligible dental/optical expense per each covered individual (Coverage under this section is Limited to Husband, wife, and dependent children.) for covered expenses during the period of July 1st through June 30th will be reimbursed to the employee within thirty (30) days of submission.
- All other dental/optical expenses in excess of two hundred dollars ($200.00) incurred during the fiscal period will be reimbursed on a prorated basis if necessary and paid on an august payroll.
- Two (2) cleanings are allowed per year. One complete set of x-rays is allowed per year.
- Limit of one hundred dollars ($100.00) toward orthodontics,
- Bleaching, implants and veneers are not covered expenses
- One optical exam is permitted
- One complete set of glasses with lenses (limit of $100 toward the frame) OR Two hundred dollars ($200.00) towards contacts.
- The amount of reimbursement under this section is limited to fifteen hundred dollars ($1500.00) per employee family.

PATIENT NAME:			**EMPLOYEE NAME:**		
PATIENT BIRTHDATE:			**EMPLOYEE ID #:**		
RELATIONSHIP TO EMPLOYEE:					
Date of Service	**Description of Service**	**Fee Charged**	**Discount extended by Dentist**	**Amount Paid by Insurance**	**AMOUNT PAID BY EMPLOYEE** (receipt must be attached)
Total Amount Charged:					
Total Paid by Insurance:					
Total Paid by Employee: **(this amount should be reflected on the attached paid receipt)**					

EMPLOYEE SIGNATURE: _____ DATE: _____

HR APPROVAL: _____ DATE: _____