City of Winston-Salem
Dental Reimbursement Plan - Claim Estimate Form

To receive an estimate of coverage for an upcoming dental expense, please complete and return this form to Savers Admin via email: Claims@SaversAdmin.com or fax: 336-759-3999, attention CWSDRP Claims.

For timely processing, be sure to complete this form in its entirety. Missing information will delay your estimate of coverage. Please allow 24 business hours for review and response.

Employee's Name: ______________________ **Phone: (**_______**)**__________________

Employee's SSN: ______________________ **City of Winston-Salem Employee ID No.** __________________

Upcoming Date of Service: ______ \ ______ \ ________ **This service is for:** ☐ **Employee** ☐ **Spouse** ☐ **Child**

If service is for Spouse or Child, provide their name: ______________________________

Only one patient per estimate form. Please complete additional form(s) for additional patient(s).

Provide a Description of the Service(s) to be performed: (Note: Cosmetic procedures are not covered.**)**__________________

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Estimated Billed Amount: $ __________________

Savers Admin will review the information provided and determine an estimated reimbursement amount. The estimate will be noted below. A completed form will then be returned to either the Employee or Dental Provider specified below.

Indicate below where Savers Admin should send its response regarding this estimate:

☐ **Send the response to the above Employee. And the response should be sent how?**

☐ **By Email to:** ____

Estimate will be sent as PDF attachment to email.

☐ **By Fax to: (**_______**)** ______________________________

☐ **By Postal Mail to:** **Employee's Name:** ______________________________

Please allow 7 days to receive response by postal mail.

Street / Mailing Address: ______________________________

City, State, ZIP: ______________________________

☐ **Send the response to the Dental Provider named below.**

Provider / Practice Name: ______________________________ **Phone: (**_______**)** __________________

And the response should be sent how? Please select one method below.

☐ **By Email to:** ____

Estimate will be sent as PDF attachment to email.

☐ **By Fax to: (**_______**)** ______________________________

Savers Admin will review the above information, indicate the reimbursement estimate below, and then return a completed copy of this form to the recipient designated above.

THE REIMBURSEMENT ESTIMATE INDICATED BELOW IS BASED ON THE INFORMATION SUBMITTED ABOVE AND IN ACCORDANCE WITH THE BENEFITS PROVIDED BY THE CITY OF WINSTON-SALEM DENTAL REIMBURSEMENT PLAN. THIS ESTIMATE IS NEITHER A GUARANTEE OF COVERAGE NOR A GURANTEE OF REIMBURSEMENT.

Member Responsibility: $______________ (This is the amount the Employee is responsible for.)

Estimated Dental Plan Reimbursement: $________________ (This is the estimated amount the Plan will pay.)

Estimate Reviewed by: ________________________ **Date Reviewed:** ____________________________

Comments: ____

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