Rebate Form

REBATE FORM for A Randomized Controlled Trial of the Effects of Offering No-fee Basic Dental Care to Older Adults (IRB19-0217). Please enter the requested information below to submit your rebate request for processing. Thank you!

STUDY ENROLLEE INFORMATION

(Information for the person/patient who is in the study and received dental services)

First Name(s) _____ Middle Name(s) _____ Last Name(s) _____

Best Phone Number: _____ Date of Birth: _____

Current Address:

_____

DENTAL PROVIDER(S) INFORMATION

Enter names of dentists, dental hygienists, or other dental provider that provided you with dental care; enter whatever information you know, such as only last names or only one of their names:

Name(s): _____

Phone Number(s): _____

Email(s) if known: _____

Address(es):

_____

DENTAL SERVICES FOR WHICH REBATE REQUESTED

Type(s) of Dental Service(s)
(you may enter more on the next page)

Date Service Received
If exact date unknown, enter best guess:

_____

Amount Paid
for service(s): _____

Importantly, please do NOT include any amount covered by insurance or discounts. Only include the final dollar amount paid by you or your proxy directly via cash, credit card, or check. This could include co-pays or out-of-pocket fees, for example.

- ◯ exam or evaluation(s)
- ◯ xray(s)
- ◯ routine cleaning of teeth or gums
- ◯ deep cleaning of gums (a.k.a. "scaling and root planing")
- ◯ filling(s)
- ◯ root canal(s), front/anterior teeth
- ◯ root canal(s), back/posterior teeth
- ◯ extraction(s) or pulled tooth
- ◯ crown(s)
- ◯ denture(s)
- ◯ bridge(s)
- ◯ implant(s)
- ◯ sealant(s)
- ◯ fluoride
- ◯ other (please describe below)

- ◯ don't know

Please add any other information about that you would like. For example, how many teeth were affected, and which teeth were they?

_____

DENTAL SERVICES FOR WHICH REBATE REQUESTED (continued)

Type(s) of Dental Service(s)
(you may enter more below)

Date Service Received
If exact date unknown, enter best guess:

_____

Amount Paid
for service(s): _____

Importantly, please do NOT include any amount covered by insurance or discounts. Only include the final dollar amount paid by you or your proxy directly via cash, credit card, or check. This could include co-pays or out-of-pocket fees, for example.

- ◯ exam or evaluation(s)
- ◯ xray(s)
- ◯ routine cleaning of teeth or gums
- ◯ deep cleaning of gums (a.k.a. "scaling and root planing")
- ◯ filling(s)
- ◯ root canal(s), front/anterior teeth
- ◯ root canal(s), back/posterior teeth
- ◯ extraction(s) or pulled tooth
- ◯ crown(s)
- ◯ denture(s)
- ◯ bridge(s)
- ◯ implant(s)
- ◯ sealant(s)
- ◯ fluoride
- ◯ other (please describe below)

- ◯ don't know

Please add any other information about that you would like. For example, how many teeth were affected, and which teeth were they?

_____

DENTAL SERVICES FOR WHICH REBATE REQUESTED (continued)

Type(s) of Dental Service(s)
(you may enter more on the next page)

Date Service Received
If exact date unknown, enter best guess:

_____

Amount Paid
for service(s): _____

Importantly, please do NOT include any amount covered by insurance or discounts. Only include the final dollar amount paid by you or your proxy directly via cash, credit card, or check. This could include co-pays or out-of-pocket fees, for example.

- ◯ exam or evaluation(s)
- ◯ xray(s)
- ◯ routine cleaning of teeth or gums
- ◯ deep cleaning of gums (a.k.a. "scaling and root planing")
- ◯ filling(s)
- ◯ root canal(s), front/anterior teeth
- ◯ root canal(s), back/posterior teeth
- ◯ extraction(s) or pulled tooth
- ◯ crown(s)
- ◯ denture(s)
- ◯ bridge(s)
- ◯ implant(s)
- ◯ sealant(s)
- ◯ fluoride
- ◯ other (please describe below)

- ◯ don't know

Please add any other information about that you would like. For example, how many teeth were affected, and which teeth were they?

_____

DENTAL SERVICES FOR WHICH REBATE REQUESTED (continued)

Type(s) of Dental Service(s)
(if you need to enter more services, please submit another form)

Date Service Received
If exact date unknown, enter best guess:

_____

Amount Paid
for service(s): _____

Importantly, please do NOT include any amount covered by insurance or discounts. Only include the final dollar amount paid by you or your proxy directly via cash, credit card, or check. This could include co-pays or out-of-pocket fees, for example.

- ◯ exam or evaluation(s)
- ◯ xray(s)
- ◯ routine cleaning of teeth or gums
- ◯ deep cleaning of gums (a.k.a. "scaling and root planing")
- ◯ filling(s)
- ◯ root canal(s), front/anterior teeth
- ◯ root canal(s), back/posterior teeth
- ◯ extraction(s) or pulled tooth
- ◯ crown(s)
- ◯ denture(s)
- ◯ bridge(s)
- ◯ implant(s)
- ◯ sealant(s)
- ◯ fluoride
- ◯ other (please describe below)

- ◯ don't know

Please add any other information about that you would like. For example, how many teeth were affected, and which teeth were they?

_____

Please sign your name for the following:

1. I certify that the information on this form is correct.
2. I authorize the University of Chicago research group to contact the provider listed above to validate the information provided and obtain records of this care at their practice.
3. I authorize the provider listed above to release the information listed above to the University of Chicago.
4. I understand that the University of Chicago research group will reimburse only a portion of the payments after validation of the bills and receipts.
5. I understand that if the required bills and receipts are not received or cannot be validated with my dental provider, I will not receive reimbursement. In that case, the study team will notify me.

Signature: _____

Date: _____

After completing and signing this form, please mail all 3 pages **and copies of your bills and receipts** to:

ATTN: UCM Dental Care Research Study
5841 South Maryland Ave MC 1005, Room M209
Chicago, IL 60637