

Dental Laboratory Reimbursement Form

Smiles for Success Foundation
216 W. Jackson Blvd.
Suite 625
Chicago, IL 60606
Phone (800) 920-2293

(Volunteers who are members of the AAWD will be reimbursed up to \$1,500 in lab fees per patient. Non-members will be reimbursed up to \$1,000 per patient. Smiles needs the original invoices mailed or faxed in order to reimburse for lab expenses.)

Dr. Name (Provider): _____
Address: _____
City, State, Zip Code: _____
Phone Number: _____

Patient Name: _____
Address: _____
Phone Number: _____
Age: _____

Patient obtained from _____ Affiliate agency associated with
Smile's for Success.

Laboratory Name: _____
Address: _____
Phone Number: _____

Type of Lab Services:

Description of treatment rendered, include tooth numbers and procedure done

Removable Prosthetics

Denture _____

Partial1 _____

Fixed Prosthetics

Crown _____

Bridge _____

Other _____