



BAYLOR UNIVERSITY DENTAL CLAIM FORM

MAY BE USED WHEN DENTAL OFFICE
DOES NOT ACCEPT ASSIGNMENT

DR Administrative Services - Claim Report Form

Have you attached a copy of your dental bill?

#1 About The Claimant

Employee (Claimant's) Name: _____

Employee SSN#: _____

Address: _____

Phone Number During Working Hours: _____

Patient Name: _____ Date of Birth: _____

Relationship to Employee: _____

#2 About This Treatment (Check Services Provided)

_____ Preventive _____ Major Restorative _____ Other
(exam, cleaning) (crowns, bridges, etc.) (describe briefly)

_____ Basic Restorative Orthodontic
(fillings, etc.)

Dentist / Specialist
(Circle one of the above)

#3 About this Claim

Name of Dentist/Specialist: _____

Total Cost of Treatment: \$ _____

Amount Paid: \$ _____

Is this claim the result of an accident at work? Yes No

Is this claim covered by any other insurance coverage? Yes No

DIRECT ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to the below-named dentist of the group dental benefits otherwise claim is payable to me.

Name of Dentist: _____

Employee Signature: _____ Date: _____

Mail completed claim form and a copy of the bill to:

DR Administrative Services, Inc.
734 Walt Whitman Road, Suite 307
Melville, NY 11747
Toll Free: (888) 791-3737
Toll Free Fax: (888) 791-1313
www.dradmin.com/baylor