Direct Reimbursement Dental/Vision Claim Report Form

Company Name: _____

Claimant Information

❒ Check if address is new

Employee Name:_____

Employee Address:_____

_____

City State Zip

Employee Social Security Number (Last four digits)_____

Patient Name: _____Date of Birth:_____

Relationship to Employee: _____

Claim Information

Name of Provider: _____

Total Cost of Treatment: $_____

_____ _____

Signature of Employee Date

Mail, Fax or Email Claim Form and Itemized Bill to:

DR Administrative Services, Inc.
734 Walt Whitman Road, Suite 307
Melville, NY 11747
Fax (888) 791-1313
claims@dradmin.com

Toll Free Hotline for questions about the plan 1-888-791-DRDP

1. The plan year may be different for each company. Check with your HR department for exact dates.
2. All claims must be filed within 90 days at the end of the plan year.
3. You must attach a complete itemized bill, including dates of service, from the provider to this form.
4. If Orthodontia benefits are lifetime, they are cumulative from all sources and may be fully paid prior to this plan.
5. See Summary Plan Document for all exclusions to this plan.