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 (exam, cleaning)
_____Major Restorative (crowns, bridges, etc.)
_____Other (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 otherwiseclaim 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.
88 Sunnyside Blvd., Suite 203
Plainview, NY 11803
Toll Free: (888) 791-3737
Toll Free Fax: (888) 791-1313
www.dradmin.com/baylor