

## Direct Reimbursement Dental Claim Report Form

Company Name: \_\_\_\_\_

### Claimant Information

Check if address is new

Employee Name: \_\_\_\_\_

Employee Address: \_\_\_\_\_

\_\_\_\_\_

City

State

Zip

Employee Social Security No.: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Employee: \_\_\_\_\_

### Claim Information

Name of Provider: \_\_\_\_\_

Total Cost of Treatment: \$ \_\_\_\_\_

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

Mail or Fax Claim Form and Itemized Bill to:

- Direct Reimbursement Dental Plans of NY, Inc.**
- DR Administrative Services, Inc.**  
**88 Sunnyside Blvd. Suite 203**  
**Plainview, NY 11803**  
**Fax (888) 791-1313**

**Toll Free Hotline for questions about the plan 1-888-791-3737**

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 of the date of service and within 60 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.