



DENTAL REIMBURSEMENT FORM

To ensure proper reimbursement, please complete this form in full

Member Services: 855-844-0626

Email claims to: helpdesk@directdentalplans.com

Website: www.directdentalplans.com

Mail claims to: Direct Dental Claims

PO Box 497

Milwaukee, WI 53201

INSTRUCTIONS: If you have paid your provider in full for dental services, please complete this form in its entirety.

REQUIRED: Upon receipt of dental services, ask your provider for a statement of billed charges and submit it with this form.

Acceptable statements will include all dental codes for the services rendered on the day of service, including arch, quad, tooth, or surface indicators where applicable. Statements will also include the provider billed amount and the amount paid by the member.

Missing information may result in delayed reimbursement or denial of coverage.

MEMBER INFORMATION					
1. COMPANY NAME		2. SUBSCRIBER ID		3. DOB	
4. FIRST NAME		5. LAST NAME		6. RELATIONSHIP TO POLICYHOLDER (check one) <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	
7. ADDRESS			8. CITY		9. STATE
					10. ZIP
OTHER DENTAL COVERAGE (if applicable)					
11. OTHER INSURANCE (OI) COMPANY		12. PLAN/GROUP #		13. PHONE	
14. POLICYHOLDER NAME (first, last)		15. SUBSCRIBER ID		16. RELATIONSHIP TO OI POLICYHOLDER (check one) <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	
17. ADDRESS			18. CITY		19. STATE
					20. ZIP
PROVIDER INFORMATION					
21. FIRST NAME		22. LAST NAME		23. NPI	
				24. PHONE	
25. ADDRESS			26. CITY		27. STATE
					28. ZIP
DENTAL SERVICES RECEIVED					
29. DESCRIPTION OF SERVICES RECEIVED		30. DATE OF SERVICE	31. BILLED AMOUNT		32. AMOUNT PAID

I certify that the above and attached information is correct and hereby authorize my dental provider to supply my employer with full information regarding services rendered, including the source of any other payments.

Name

Date

*** PLEASE ATTACH YOUR PROVIDER'S STATEMENT OF BILLED CHARGES MEETING THE CRITERIA DESCRIBED ABOVE ***