BENSON PUBLIC SCHOOLS

DIRECT REIMBURSEMENT DENTAL BENEFIT PLAN

CLAIM FORM

Claims should be filed within ninety (90) days of the date claim was incurred, and must be filed within 90 days after the end of the plan year (plan year ends August 31). Submit a separate claim for each individual and for each treatment. Claims are processed every week.

ABOUT THE CLAIMANT:

(Please print or type)

Employee Name _____

Patient Name _____

Employee Address _____

ABOUT THIS TREATMENT

Check one: ____ Preventive (exam, cleaning) ____ Basic Restorative (fillings, etc.) ____ Major Restorative (crowns, bridges, etc.) ____ Orthodontics (braces)

ABOUT THIS CLAIM

Name of Dentist/Specialist _____

Address _____|_____|_____|_____

Street Address | City | State | Zip

To your knowledge, is this part of an ongoing treatment program for which there will be additional expenses?

_____ Yes _____ No

Date of Treatment _____

Total Cost of treatment for this claim only $_____

Amount paid by an insurance plan or other dental reimbursement plan $_____

Amount paid by employee after insurance or other reimbursement $_____

Submit this form along with

1) Copy of statement from dentist listing patient, type of treatment, date, and charges
2) Settlement form (EOB) from insurance company or other reimbursement plan, if applicable. Refer to your plan document or check with the Plan Administrator if you have questions regarding coverage.

Signature of Employee _____ Date_____

NOTE: Reimbursement checks will be made payable to the employee and will be distributed to you by your employer.

Mail, fax or email claims form with supporting documents to: Dental Claims
DR Administrative Services, Inc.
734 Walt Whitman Road, Suite 307
Melville, NY 11747
Fax: (888) 791-1313 or (631) 629-4111
claims@dradmin.com

Toll Free Hotline for questions: (888) 791-3737 or (631) 629-4110