Dental/Vision Claim Report Form

Company Name: _____

Claimant Information

☐ Check if address is new

Employee Name:_____

Employee Address:_____

_____

City State Zip

Last four digits of Employee Social Security No._____ Date of Birth_____

Patient Name:_____

Relationship to Employee_____

Claim Information

Name of Provider:_____

Total cost of treatment $_____

_____ _____

Signature of Employee Date

Mail, Email or Fax Claim form and **ITEMIZED Bill** to:

DR Administrative Services, Inc.
20 Broad Hollow Road, Suite 3007
Melville, NY 11747
Fax (888)791-1313
claims@dradmin.com

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

1. All claims must be filed within 90 days of the end of the plan year.
2. You must attach a complete itemized bill, including dates of service, from the provider to this form.
3. See Summary Plan Document for all exclusions to this plan.