DENTAL REIMBURSEMENT FORM

To ensure proper reimbursement, please complete this form in full.

Member Services:
855-844-0626

Website:
www.directdentalplans.com

Email:
helpdesk@directdentalplans.com

Mail Claims To:
Direct Dental Pay
Member Claims
PO Box 76
Milwaukee, WI 53201

INSTRUCTIONS: If you have paid your provider in full for dental services, please complete this form in its entirety. Claim forms missing information cannot be processed. Your provider can assist you with completion of the form.

MEMBER INFORMATION		
Group Name:		
Patient Name:	**Insurance ID Number:**	
Patient Phone Number:		**Date of Birth:**
Address: (Street, City, State, ZIP Code)		

PROVIDER INFORMATION	
Provider Number (Internal use only) **72113**	Location Number (Internal use only) **55050**

DENTAL SERVICES RECEIVED

DATE OF SERVICE	DESCRIPTION OF SERVICES	SERVICES (Dental Code, if applicable: Tooth Number, Tooth Surface, Quad Service)	AMOUNT PAID
		Code: Tooth No.: Tooth Surface: Quad: Arch:	
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		Code: Tooth No.: Tooth Surface: Quad: Arch:	

I certify that the above is accurate.

Name/Signature _____ Date _____