

SLV Mental Health

Direct Reimbursement Dental & Vision Claim Form – Assignment of Benefits

Your Plan Year is January 1 – December 31

Claims must be submitted within 90 days following the end of the above plan year.

Your Plan Pays:

Dental

100% of the first \$200 of expenses, then
a \$50 deductible, then
80% of the next \$500 of expenses, then
50% of the next \$800 of expenses.
Maximum Annual Benefit of \$1,000

Vision

100% of the first \$100 of expenses
per year, then
50% of the next \$400 of expenses
Maximum Annual Benefit of \$300

(Please refer to the Orthodontic Treatment Plan form for instructions on Orthodontic reimbursement).

Employee Information: (MUST BE COMPLETED)

Name:	
Address: <input type="checkbox"/> Check if address is new.	
Social Security #:	Phone #:
Patient's Name:	
Relationship:	Patient's Date of Birth:
If reimbursement is for a child ages 19 – 25, please provide proof of full time student status.	
Are benefits to be paid to the doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provider's W-9 form is required to meet I.R.S. regulations.	
Signature:	

Doctor Information: (MUST BE COMPLETED)

Doctor Tax ID #:(Required)	
Doctor Name:	
Doctor Address:	
Phone #:	Total Cost of Treatment: \$ _____
Was the treatment for an accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DO NOT SEND IN TREATMENT PRE-ESTIMATES OR X-RAYS	

YOU MUST ATTACH AN ORIGINAL ITEMIZED BILL to this form and mail to:
Direct Reimbursement Benefit Plans/P.O. Box 71549/Newnan, GA 30271
Phone 888-745-3274 Fax 770-683-1099

- ◆ Reimbursement is made without regard to the procedure code. Please refer to your employee booklet for specific exclusions and details. COSMETIC CARE IS NEVER COVERED.
- ◆ You should expect your reimbursement check within ten business days.