Dental Claim Form – Submitted by Employee

Employer____

Group #____

Employee:____

Social Security No______-______-______Member ID______________________Birth Date ______________

Address____

City____State____________________Zip_______________

Phone No____________________________________E-mail______________________________________

Has your address changed since your last claim? ☐ **Yes** ☐ No

Patient Name____

Relationship to Employee:_______________________________________Birth Date: ________________

Dentist____

Phone No.____

Address____

City____State____________________Zip _______________

Please attach a copy of the original, itemized bill. The claim will not be processed without it.

Under penalty of law, I agree to the following:
This claim occurred while the patient was covered by this plan. The attached bill is an original, unaltered bill.

Employee Signature____Date _____________________

FOR FASTEST SERVICE PLEASE HAVE YOUR PROVIDER SUBMIT CLAIM ELECTRONICALLY TO PAYER ID #41101. YOU MAY ALSO FAX, EMAIL, OR MAIL THIS FORM AND SUPPORTING DOCUMENTATION TO:

Fax to:

1-888-308-6009

Or scan and e-mail to:

claims.t5a@90degreebenefits.com

Or mail to:

Simple, 2810 Premiere Pkwy, Ste. 400, Duluth, GA 30097

Customer Service: 800-270-4158

REMEMBER TO INCLUDE A COPY OF THE ORIGINAL, ITEMIZED BILL, AND ANY EXPLANATION OF BENEFITS FROM YOUR PRIMARY DENTAL CARRIER.

Keep a copy for your records.