# 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.