

Direct Reimbursement Dental Plan Claim Form

All items must be completed to avoid delay in processing your claim.

Employer Name (No Abbreviations): _____

Employee Name: _____ **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (____) _____ **Email:** _____

Patient Name: _____ **Patient SSN:** _____

Relationship to Employee: **Self** **Spouse** **Child**

Is the patient covered by another dental plan? **Yes** **No**

If yes, please attach a copy of the payment and explanation of benefits from the other dental plan.

Certification: These expenses were incurred by me and/or my eligible spouse or eligible dependents during the plan year while I have been a covered participant and to the best of my knowledge are reimbursable by the plan. I certify that I have not been reimbursed for the above expenses, except as noted above, and that I will not seek reimbursement under any other plan covering health benefits, such as a spouses' plan. I also understand that privacy regulations prohibit Mass Group Marketing, Inc. from discussing claims with anyone other than the participant. If my child is 19 years of age or older, I certify they are a full time student and I may be required to provide proof of full time status. I certify that I have made payment for charges of which I am requesting reimbursement and an itemized statement and original paid receipt is attached. I authorize the dental care provider to release all information relating to this claim to Mass Group Marketing, Inc.

Employee Signature

Date

Submit your claim to: Mass Group Marketing, Inc.
Dental Claim Department
2121 N. Glenville Drive
Richardson, Texas 75082
Fax (469) 385-4620



Claim Questions: (972) 881-2255