

Dental Claim Form – NON AOB

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
Was treatment a result of an accident? Yes Was treatment for cosmetic care? Yes	No No No	
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 <u>PAYER ID #41101</u> . YOU MAY ALSO FAX, EMAIL DOCUMENTATION TO: Fax to: 1-888-308-6009 Or scan and e-mail to: claims@simple.us Or mail to: Simple, 2810 Premiere Pkwy, S Customer Service: 800-270-4158 PEMEMBER TO INCLUDE A COPY OF THE OPH	, OR MAIL TH	HIS FORM AND SUPPORTING
REMEMBER TO INCLUDE A COPY OF THE ORIGINAL, ITEMIZED BILL.		

Keep a copy for your records.