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** ☐ **No**
Was treatment for cosmetic care? ☐ **Yes** ☐ **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 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@simple.us
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.
Keep a copy for your records.