

# CLAIM FORM

## Dental Direct Reimbursement Coverage

EMPLOYEE First Name: \_\_\_\_\_

EMPLOYEE Last Name: \_\_\_\_\_

EMPLOYEE Social Security Number: \_\_\_\_\_

Street Address/PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Location: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Date of Claim(s): \_\_\_\_\_ Amount of claim(s): \_\_\_\_\_

Dental Provider Name: \_\_\_\_\_

Dentist must submit the universal American Dental Association form to the address below with this form.

Mail or Fax to: Eagles, Benefits by Design, Inc. (Eagles)  
2336 SE Ocean Blvd., Suite 301  
Stuart, FL 34996

Fax Number: (772)334-7059

If you have questions, please call 1-800-726-5603.

PLEASE NOTE: All claims for the plan year must be filed within 90 days after the plan year ends.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_