Windsor HR Services, Inc.

Direct Reimbursement Dental Claim Form

Your Plan Year is January 1 – December 31

All claims must be submitted **no later than three months** following the end of the above plan year.

Employee Information: (MUST BE COMPLETED)

Name:	
Address: ☐ **Check if address is new.**	
Social Security #:	**Phone #:**
Patient's Name:	
Relationship:	**Patient's Date of Birth:**
If reimbursement is for a child ages 19 – 25, please provide proof of full time student status.	
Signature:	

Doctor Information: (MUST BE COMPLETED)

Doctor Tax ID #:(Required)	
Doctor Name:	
Doctor Address:	
Phone #:	**Total Cost of Treatment: $ ___________**
Was the treatment for an accident or injury? ☐ **Yes** ☐ **No**	
DO NOT SEND IN TREATMENT PRE-ESTIMATES OR X-RAYS	

YOU MUST ATTACH AN ORIGINAL ITEMIZED BILL to this form and mail, fax, or email to:

Direct Reimbursement Benefit P O Box 16887 Lubbock, TX 79490

Phone 888-745-3274 Fax 214-574-2348

nnggdrclaims@healthsmart.com

- Reimbursement is made without regard to the procedure code. Please refer to your employee booklet for specific exclusions and details. COSMETIC CARE IS NEVER COVERED.
- You should expect your reimbursement check within ten business days.