BrightBenefits

DENTAL REIMBURSEMENT FORM

To ensure proper reimbursement, please complete this form in full.

Member Services: 855-806-5197

Mail claims to: BrightBenefits
PO Box 1424
Milwaukee, WI 53201

INSTRUCTIONS: If you have paid your provider in full for dental services, please complete this form in its entirety.
REQUIRED: Upon receipt of dental services, ask your provider for a statement of billed charges and submit it with this form **OR** have your provider complete the form including signature(s) at the bottom as confirmation of services and payment.

Acceptable statements will include all dental codes for the services rendered on the day of service, including arch, quad, tooth, or surface indicators where applicable. Statements will also include the amount paid by the member. **Missing information may result in delayed reimbursement or denial of coverage.**

MEMBER INFORMATION			
1. COMPANY NAME	2. SUBSCRIBER ID	3. DOB	
4. FIRST NAME	5. LAST NAME	6. RELATIONSHIP TO POLICYHOLDER (check one) ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
7. ADDRESS	8. CITY	9. STATE	10. ZIP

PROVIDER INFORMATION			
21. FIRST NAME	22. LAST NAME		
23. NPI #	24. Tax ID #	25. Phone #	
26. ADDRESS	27. CITY	28. STATE	29. ZIP

DENTAL SERVICES RECEIVED			
30. DATE OF SERVICE	31. DESCRIPTION OF SERVICES	32. CODES FOR SERVICES	33. AMOUNT PAID

I certify that all the submitted information is accurate and reflects all services have been rendered and paid in full.

Member Signature ____________________ Date ____________

Dental Provider's Signature ____________________ Date ____________

*** MEMBER MAY COMPLETE FORM WITH SIGNATURE AND ATTACH YOUR PROVIDER'S STATEMENT OF BILLED CHARGES MEETING THE CRITERIA DESCRIBED ABOVE, OR HAVE YOUR PROVIDER COMPLETE THE FORM ON YOUR BEHALF INCLUDING THE SIGNATURE LINE AS CONFIRMATION OF SERVICES AND PAYMENT***