Direct Reimbursement Benefit Plans Claim Form

Employee Information – Must Be Completed

Employee Name

Employer

Address ☐ Check if address is new.

City

State

ZIP

Telephone Number

Patient Name

Relationship

Patient's Date of Birth

Employee Signature

Date

Provider Information: Must Be Completed

Provider Name

Provider Address

City

State

ZIP

Phone Number

Total Cost of Treatment

Was the treatment for an accident or injury? ☐ Yes ☐ No

DO NOT SEND IN TREATMENT PRE-ESTIMATES OR X-RAYS.

Please submit this form, along with an itemized bill supporting the reimbursement request to:

Customer Service Number:

Please refer to your HealthSmart Reimbursement Card.

Claims

HealthSmart Benefit Solutions

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