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

Are benefits to be paid to the doctor? ☐ **Yes** ☐ **No**
If yes, provider's W-9 form is required by meet IRS regulations.

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 billing supporting the reimbursement amount requested to:

Customer Service
Phone: 844.607.8559

Claims
HealthSmart Benefit Solutions
P.O. Box 16887
Lubbock, TX 79490
Email: nnggdrclaims@healthsmart.com
Fax: 806-473-3134