Combined Insurance Services

DENTAL REIMBURSEMENT PLAN
CLAIM FORM

THIRD PARTY CLAIMS ADMINISTRATOR
COMBINED INSURANCE SERVICES (CIS), 1701 NE 42nd Ave #200, Ocala, Fl 34470.
Phone # (352) 237-2181. Fax # (352) 237-2040

- CLAIMS SUBMISSION
  Submit claims to CIS.
  * Complete the employee section below and attach a copy of your dentist's itemized statement.
  * A separate reimbursement claim form must be used for each patient.
  * Multiple bills for the same patient may be attached to one reimbursement claim form.
  * Dentist itemized statement must be attached.
  * If claim is for orthodontic monthly payments, submit original payment plan contract for file and each month thereafter, submit monthly payment/coupon receipt.

- DEADLINE FOR SUBMISSION OF CLAIMS
  All Plan Year claims must be submitted for reimbursement by the 365th day of the following Plan Year.
  Claims submitted after this date will not be processed.

CLAIM INFORMATION
EMPLOYEE SECTION

EMPLOYER: _____

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EMPLOYEE:_____ **SOC. SEC. #:** _____ **DAY PHONE:** _____

PATIENT: _____**RELATIONSHIP:**_____ **DENTIST** _____

DESCRIPTION OF SERVICE:_____**AMOUNT: $**_____

EMPLOYEE'S SIGNATURE:_____**DATE:**_____