



Dental Claim Form – Submitted by Employee

Employer _____

Group # _____

Employee: _____

Social Security No _____ - _____ - _____ Member ID _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Phone No _____ E-mail _____

Has your address changed since your last claim? ☐ Yes ☐ No

Patient Name _____

Relationship to Employee: _____ Birth Date: _____

Dentist _____

Phone No. _____

Address _____

City _____ State _____ Zip _____

Please attach a copy of the original, itemized bill. The claim will not be processed without it.

Under penalty of law, I agree to the following:

This claim occurred while the patient was covered by this plan. The attached bill is an original, unaltered bill.

Employee Signature _____ Date _____

**FOR FASTEST SERVICE PLEASE HAVE YOUR PROVIDER SUBMIT CLAIM ELECTRONICALLY TO
PAYER ID #58102.**

YOU MAY ALSO FAX OR MAIL THIS FORM AND SUPPORTING DOCUMENTATION TO:

Fax to:

1-888-308-6009

Or mail to:

Simple, 2810 Premiere Pkwy, Ste. 400, Duluth, GA 30097

Email: claims.t5a@90degreebenefits.com

Customer Service: 800-270-4158

**REMEMBER TO INCLUDE A COPY OF THE ORIGINAL, ITEMIZED BILL, AND ANY EXPLANATION OF
BENEFITS FROM YOUR PRIMARY DENTAL CARRIER.**

Keep a copy for your records.