DENTAL MEMBER CLAIM FORM

Fill out a separate form for each member submitting claims for covered services.
See instructions below for submission.

Employee Information

Employer		SSN or ID #	
Name		Date of Birth	
Address			
Phone Number(s)		Other	
Email			

Patient Information

Patient Name		Relation to Subscriber	☐ Spouse ☐ Son ☐ Daughter ☐ Other
Date of Birth			
Is this request related to a work accident or injury?	☐ No ☐ Yes	Date of Injury	
Is this claim related to a medical emergency?	☐ No ☐ Yes	Date of Emergency	

Claim Information

Claim	Name of Member	Date(s) of Service	Description of Service(s)	Diagnosis/Illness (if applicable)	Total Charges	Amount Paid by You
1						
2						
3						
4						
				Total Claims Reimbursement		

Other Health Insurance – Policyholder Information

This section only needs to be completed if the patient was/is covered by other insurance (including Medicare) at the time of the claim.

Name of Policyholder			
Date of Birth		Individual to Receive Reimbursement:	
Policyholder Employer			
Employer Address			
Other Vision Carrier		Other Policy Number	
Relation to Subscriber	☐ Self ☐ Spouse ☐ Other	Forms Prepared by	

Form Submission

Phone: (888) 326-2555

Secure Fax: (916) 467-1401

Mailing Address: BRMS Claims
P.O. Box 2140
Folsom CA 95763

Instructions:

- Enclose a **copy of all bills AND proof of payment** for reimbursement.
- Verify that bills contain the date and description of service, the amount, and the provider's name stamped on receipt.
- **Sign your claim form.**
- **Submit claim form** to BRMS mailing address above.
- **Call** the phone number above if you have any questions.
- BRMS may request further information if necessary to process your claim according to IRS guidelines.

Acceptable Documentation includes the following:

a.) Explanation of Benefits (EOB) from insurance carrier
b.) Itemized Statement or bill from your provider which includes:
- Provider name
- Patient name
- Description of service
- Original date of service (the date of service, not the date of payment, must fall within the plan year for which you are currently enrolled.)
- Patient portion of charge(s)

Employee Signature _____ Date _____