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 _____

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 #72091.

YOU MAY ALSO EMAIL, FAX, MAIL or ONLINE THIS FORM AND SUPPORTING DOCUMENTATION TO:

Email: claims.t1@90degreebenefits.com
Fax: 318.747.5074
Mail: 90 Degree Benefits, P.O. Box 71120, Bossier City, LA 71171
Customer Service: 855.502.7223
Register on www.90degreebenefits to submit claims online.