# HR Concepts, LLC

"Your Third Party Administrator of Choice"

## Dental Reimbursement/Claim Form

**Part I. Employee Information ( ❑ Please check if this is a new address)**

Employee Name: ______________________________ SS # ___ ___ ___-___ ___-___ ___ ___ ___

Mailing Address: __________________________ City: ___________________ St.: _____ Zip: _____

Street Address: __________________________ City: ___________________ St.: _____ Zip: _______

Email Address for All Correspondence: ________________________________________________

Telephone: ______________ Employer Name: _______________________ Plan Year: ___________

**Part II. Instructions for submitting form (Please read carefully)**

1 Fill out entire form and sign the bottom

2 Reimbursement is only for expenses that will not be reimbursed from any other source. These expenses must have been incurred during the plan year in which reimbursement is requested. You have up to 90 days after the end of a plan year to submit expenses that you incurred during the plan year that just ended.

3 All 3rd party documentation supporting your request for reimbursement must accompany this request. This supporting documentation must show date of service (Not the payment date), amount of expense that you are responsible for, who it was for, and a description of expense.

**Part III. Claim Information**

**Please check the reimbursement option you prefer (check to be mailed or money placed on your Debit Card)**

☐ **Check mailed to above address** ☐ **Money Authorized on VISA**

| Name of Covered Person | Date of Service | Type of Service | Description of Services | Amount of Claim |
|---|---|---|---|---|
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| | | | | |
| | | | Total Reimbursement of This Claim Form | |

**Part IV. Signature**

The above statements and submitted information for reimbursement are true. I am only submitting for reimbursement for expenses that I incurred for myself or legal dependents. I certify that I have not been nor will I be reimbursed for these submitted reimbursements from any other source. I further certify that I will not claim these expenses as a tax deduction.

**Employee Signature:** ____________________________________ **Date:** ______________________

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Phone: 603-647-1147 • Fax: 1-866-978-7868 • email: info@hrconcepts.biz
www.HRConcepts.biz • 111 Charles Street • Manchester, NH 03101