Direct Reimbursement Dental

Plan Year: ________________

Submit Claims To:

CareFlex Benefit Solutions
205 West Dares Beach Road
Prince Frederick, MD 20678
Claims Fax: (410)-414-8415
Questions: (888) 577-2762

Employee Information – *Must Be Completed*		
Name:	**SSN:**	**Employer:**
Address:	☐ ***Check here if this is a new address***	
City:	**State:**	**Zip:**
Phone #:	**Email Address:**	
Patients Name:	**Patients Date of Birth:**	
Relationship:	**Date of Service:**	**Total Charge:**
Signature:	☐ ***Check here if you would like the balance to be processed under your Flexible Spending Account***	

Note: If reimbursement is for a child ages 19-23; you must provide proof of full time student status.

Provider Information – *Must Be Completed*		
Name:	**Tax ID:**	
Address:	**Phone #:**	
City:	**State:**	**Zip:**
Date of Service:	**Total Charge: $**	
Was the treatment related to an accident or injury? ☐ **Yes** ☐ **No**		
Signature:		

Please attach your ADA form or Statement of Services from your provider.

Do not send in x-rays.