



Combined Insurance Services
**DENTAL REIMBURSEMENT PLAN
CLAIM FORM**

THIRD PARTY CLAIMS ADMINISTRATOR

COMBINED INSURANCE SERVICES (CIS), 1701 NE 42nd Ave #200, Ocala, FL 34470.

Phone # (352) 237-2181. Fax # (352) 237-2040

➤ **CLAIMS SUBMISSION**

Submit claims to CIS.

- * Complete the employee section below and attach a copy of your dentist's itemized statement.
- * A separate reimbursement claim form must be used for each patient.
- * Multiple bills for the same patient may be attached to one reimbursement claim form.
- * Dentist itemized statement must be attached.
- * If claim is for orthodontic monthly payments, submit original payment plan contract for file and each month thereafter, submit monthly payment/coupon receipt.

➤ **DEADLINE FOR SUBMISSION OF CLAIMS**

All Plan Year claims must be submitted for reimbursement by the 365th day of the following Plan Year.

Claims submitted after this date will not be processed.

**CLAIM INFORMATION
EMPLOYEE SECTION**

EMPLOYER: _____

EMPLOYEE: _____ **SOC. SEC. #:** _____ **DAY PHONE:** _____

PATIENT: _____ **RELATIONSHIP:** _____ **DENTIST** _____

DESCRIPTION OF SERVICE: _____ **AMOUNT:** \$ _____

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____