DirectPay·Dental
a direct reimbursement plan

REQUEST FOR REIMBURSEMENT

PLEASE DUPLICATE THIS FORM FOR FUTURE CLAIMS

Submit Request for Reimbursement and supporting documentation:

BY FAX: **608-663-2754**

BY MAIL: **TASC**
PO Box 7308
Madison, WI 53704-7308

SUPPORT: **1-800-422-4661**

Name of Participant: _____

Address: _____

_____

_____

Client ID#:
Participant ID#:

Name of Claimant: _____

Claimant's relationship to employee: ☐ Self ☐Spouse ☐Son ☐Daughter ☐Other

Is the dependant covered under another dental/vision program? ☐Yes ☐No

If yes, give name of company: _____and attach a payment statement to this request.

Check one: ☐Pay to Provider (If Pay to Provider is checked, we need the Provider Tax ID, and Address. If not provided, Payment will be sent to the employee)
☐Pay to Employee (If no box is checked, payment will be sent to the employee)

Month / Day / Year	Benefit Code	Service Amount	Service Description	Name of Claimant
		.		
		.		
		.		

BENEFIT CODES
DE – Dental Expense **VI – Vision Expense** **OR - Orthodontia**

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am requesting reimbursement for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants

Employee Signature (required) _____ Date ___ / ___ / ___

REIMBURSEMENT TIPS – To ensure prompt and accurate reimbursements

- Submit itemized Request for Reimbursement Form and itemized paid Receipt to address or fax listed above.
- **Include required claim substantiation** (itemized bill or receipt) **along with your Request for Reimbursement Form.**
- Incomplete Requests for Reimbursement will delay processing.
- **Dates of Service always represents the date your services are incurred or rendered,** not always the date they were paid for.
- Enter the amount requested for each request in the Request Amount Box. One request form cam be used for multiple expenses.
- **Your signature is required** on each Request for Reimbursement Form.