Post-Service Emergency Dental Care Claim Form

Please complete the steps below to be reimbursed for emergency dental care services provided by an out-of-network dentist. Fill out the form, include an itemized dental bill showing the emergency dental care services provided, and send it to Dental Health Services at the address provided at the bottom of this form. That's it! It really is that simple.

Step 1: Complete Your Information (All fields are required)

Subscriber

(a person whose relationship as the primary enrollee is the basis for coverage under this agreement)

Subscriber Last Name | Subscriber First Name | M.I. | Member Number

Address | Apt. # | City | State | Zip Code

Primary Phone | Cell Phone | Email | Date of Service | Out-of-Network Dentist Name (Dentist)

Dentist Phone Number | Dentist Address | City | State | Zip Code

Enrollees to be reimbursed for out-of-network emergency dental care services

Last Name	First Name	Gender	Birth Date	Relation to Subscriber	Reason for seeing out-of-network dentist

Step 2: Attach a copy of the itemized dental bill

Request a copy of the itemized receipts from the out-of-network dentist who provided the emergency dental care treatment, showing the services provided. Dental Health Services reimburses for the amount beyond all applicable copayments for dental work done to eliminate pain, swelling or bleeding.

Step 3: Send the itemized dental bill and Post Service Dental Care Emergency Claim Form to Dental Health Services

Within 60 days of the occurrence, send the Post-Service Emergency Dental Care Claim Form and itemized bill to:

Dental Health Services
Attn: Claims Department
100 West Harrison Street
Suite S-440, South Tower
Seattle, WA 98119

If you do not submit this information within 60 days, Dental Health Services reserves the right to refuse payment.

Dental Health Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Dental Health Services. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-866-756-4259.

本通知有重要的訊息。本通知有關於您透過[插入SBM項目的名稱 Dental Health Services 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字 1-866-756-4259.