AgBenefits Dental

a direct reimbursement plan

PLEASE DUPLICATE THIS FORM FOR FUTURE CLAIMS
Submit Request for Reimbursement and supporting documentation:
BY FAX: 806-350-7886
BY MAIL: Bentegrity, P.O. Box 211575
Eagan, MN 55121
EDI#TXABA
SUPPORT: 806-568-2600

GROUP ID#:_____

PARTICIPANT ID#: _____

Name of Claimant: _____

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

Is the dependant covered under another dental program? (circle one) Yes No

if yes, give name of company and attach a payment statement to this request

Company Name:_____

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 employer)**

☐ **Pay to Employee (If no box is checked, payment will be sent to the employee)**

NAME OF CLAIMANT:_____

Month / Day / Year	Benefit Code	Service Amount	Service Description
_____ / _____ / _____	_____	_____	_____

NAME OF CLAIMANT:_____

Month / Day / Year	Benefit Code	Service Amount	Service Description
_____ / _____ / _____	_____	_____	_____

NAME OF CLAIMANT:_____

Month / Day / Year	Benefit Code	Service Amount	Service Description
_____ / _____ / _____	_____	_____	_____

BENEFIT CODES: DE - Dental 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 for 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 for can be used for multiple expenses.
- **Your signature is required on each Request for Reimbursement Form.**