



## Direct Reimbursement Benefit Plans Claim Form

### Employee Information – Must Be Completed

Employee Name		Employer	
Address <input type="checkbox"/> Check if address is new.		City	State ZIP
Telephone Number	Employee ID Number		
Patient Name			
Relationship	Patient's Date of Birth		

If the patient is a covered child age 19 or over, proof of full time student status may be required. Please check your Summary Plan Description (SPD) for details.

Are benefits to be paid to the doctor? \*  Yes  No

If yes, provider's W-9 form is required to meet I.R.S. regulations.

\*Not all plans allow for payment to be made to the provider.

Employee Signature	Date
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### Provider Information: Must Be Completed

Tax ID Number: (Required if payment is to be made to the provider.)

Provider Name			
Provider Address	City	State	ZIP
Phone Number	Total Cost of Treatment		

Was the treatment for an accident or injury?  Yes  No

**DO NOT SEND IN TREATMENT PRE-ESTIMATES OR X-RAYS.**

Please submit this form, along with an itemized billing supporting the reimbursement amount requested to:

**Customer Service**  
Phone: 888.745.3274 | Fax: 806.473.3134

**HealthSmart Benefit Solutions**  
P.O. Box 16887  
Lubbock, TX 79490  
Email: [nnggdrclaims@healthsmart.com](mailto:nnggdrclaims@healthsmart.com)