Direct Reimbursement Benefit Plans Claim Form

Employee Information – Must Be Completed

Employee Name | Employer |

Address ☐ 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 |

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