Sun Coast PBA
Direct Reimbursement Dental Plan

*****ALL CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS of TREATMENT DATE**
ANY **CLAIMS SUBMITTED AFTER WILL BE DENIED*****

CLAIM FORM
Dental Direct Reimbursement Coverage

Employee Name:_____

Last 4 of Employee's SSN#:_____

Street Address/PO Box:_____

City:_____ State: _____ Zip: _____

Phone Number:_____

Patient's Name:_____ Relationship: _____

Date of Claim: _____ Amount of Claim:_____

DO YOU HAVE OTHER DENTAL INSURANCE? Yes _____ No _____

IF YES, list name of insurance co. & attach their EOB for date of claim you are submitting:

_____

ARE BENEFITS TO BE PAID TO THE PROVIDER? Yes _____ No _____
IF YES, I hereby authorize payments be made directly to the provider

Signature _____ Date _____

Please attach receipts and the EOB from your other insurance co (if applicable) & mail or fax to:

Sun Coast PBA
14141 46th Street N #1205
Clearwater, FL 33762
(Phone) 727-532-1722 • (Fax) 727-530-4816