Samera Health

Dental Reimbursement Claim Form

COMPLETE the following and attach itemized statements. (Cash register receipts cannot be accepted)

1. Employer/Group Name_____
2. Employee's name: Last_____ First: _____
3. Employee's mailing address: _____

   City_____State_____ Zip_____
4. Phone number: _____
5. Patient's name: Last_____ First: _____
6. Does the patient have other health coverage: Yes_____ No_____

   Name of other insurance company:_____

   Policy number:_____ Effective date:_____
7. Payment for the attached claims should be made to: Employee_____ Provider_____

I authorize the release of any medical information necessary to process the claim and request payment of benefits to either myself or to the provider as stated above. I certify the above information to be true to the best of my knowledge. I also understand that any misrepresentation may be cause for dismissal and/or nonpayment of claims.

8. Employee signature:_____ Date:_____

Mail completed form to:
Samera Health
PO Box 126
Smithfield UT 84335

You may also fax or email your claim as follows:
Fax claims to: 435-563-4035
Email: claims@samerahealth.com