



**SUBMIT CLAIM TO** ASR CORPORATION  
 P.O. BOX 6392  
 GRAND RAPIDS, MI 49516-6392  
[claimsubmit@asrhealthbenefits.com](mailto:claimsubmit@asrhealthbenefits.com)  
 Fax: (616) 464-4458

**DO NOT WRITE ON SHADED AREAS**

**GROUP #692**

# DENTAL REIMBURSEMENT CLAIM FORM

PATIENT NAME		RELATIONSHIP TO EMPLOYEE		SEX	BIRTHDATE	DATE	Location Code
<b>*ONE NAME PER CLAIM FORM*</b>		(CIRCLE)	OTHER	(CIRCLE)			
EMPLOYEE NAME		EMPLOYEE SOCIAL SECURITY NUMBER		GL#			
Last	First	Middle					
PAYMENT DESCRIPTION							
Address:			DENTAL REIMBURSEMENT				
CITY STATE ZIP			Is payment for Orthodontics? (CIRCLE)		AMOUNT TO BE PAID		
					\$		
<b>*COMPLETE THIS SECTION IF PATIENT IS COVERED BY ANOTHER PLAN</b>	Subscriber Name		Social Security Number		Name and Address of Employer		
	Plan Name		Group Number		Name and Address of Carrier		
<b>Oral Surgery-Wisdom Teeth Extraction is covered under the WMHIP Community Blue Health Plans, please review instructions on how to submit your reimbursement request to BC/BS. Instruction are posted on the HR/Benefits Website</b>							

\*If you are covered by another plan, please submit documentation from other plan that eligible charges were processed (e.g., an EOB).

DATE OF SERVICE	DESCRIPTION OF SERVICE	PROCEDURE CODE (if available)	\$AMOUNT
<b>SUBTOTAL</b>			
LESS AMOUNT PAID BY OTHER INSURANCES			
LESS DISCOUNTS			
<b>TOTAL</b>			

DOCTOR NAME OR SERVICE PROVIDER \_\_\_\_\_ TELEPHONE \_\_\_\_\_

**I HEREBY CERTIFY:**

1. That the above is a true report of expenses paid by myself, not having been reimbursed from another source
2. That the patient indicated is either myself, my spouse, or my eligible dependent children.
3. That I grant permission to contact my doctor for clarification of the billing statement attached.

**NOTE: Be advised that any person knowingly and with intent to injure, defraud or deceive Grand Rapids Community College in filing incomplete or misleading information may be guilty of a criminal act punishable under law. Grand Rapids Community College reserves the right to determine its own level penalty up to and including discharge.**

Employee Signature \_\_\_\_\_ **Signature Required**  
 Employee Bargaining Group \_\_\_\_\_

**ATTACH ITEMIZED BILL AND PROOF OF PAYMENT**

## Grand Rapids Community College Dental & Vision Claim Submission Process

Please carefully follow the steps listed below to file a claim under this plan:

- STEP 1 The Employee must pay the full cost of Covered Expenses for dental or vision care. **NOTE: If the Participant does not have other dental or vision plan coverage, the Participant can proceed to step 4. If the Participant has other coverage, he or she must continue with steps 2-5.**
- STEP 2 File a claim for dental or vision care expenses with any other dental or vision plan under which coverage was elected (e.g., dental or vision coverage under a spouse's employer's group health plan).
- STEP 3 Obtain documentation from the other dental or vision plan that eligible charges were processed and that a balance on the charges remains outstanding (e.g., an EOB).
- STEP 4 Obtain the Grand Rapids Community College (GRCC) Dental or Vision Reimbursement Form. Complete all of the requested information. This claim form is available at the GRCC HR/Benefits Office or Online at <http://grcc.edu/humanresources/healthbenefits>. If you need assistance contact the GRCC HR/Benefits Office at (616) 234-4175 or (616) 234-4052.
- STEP 5 Sign and date the claim form where indicated, attach the EOB from the other health plan, if any, attach a copy of the itemized bill or invoice, attach evidence of payment, and then submit all to ASR via one of the following methods:

Mail: ASR Corporation P.O. Box 6392 Grand Rapids, Michigan 49516-6392  
Email: [claimsubmit@asrhealthbenefits.com](mailto:claimsubmit@asrhealthbenefits.com)  
Fax: (616) 464-4458

Participants should submit claims for reimbursement within 60 days from the date of service.

### Questions?

Call ASR Health Benefits Monday-Friday 8 am to 4:30 pm

Employees with last name beginning A-L

Contact: Claims Analyst-Marcie B: (616) 957-1751, extension 3093

Employees with last name beginning M-Z

Contact: Claims Analyst-Sue L: (616) 957-1751, extension 3013

