

## **Dental Reimbursement Form**

Our plan covers dental services from licensed dentists within your service area up to an annual limit. Refer to your Evidence of Coverage for your plan's limit.

To receive reimbursement, you must submit the following:

1. Reimbursement form 2. Your itemized receipt(s) 3. Claim form (If provided by your dentist)

Please submit these items to:

DentaQuest Claims PO Box 2906

Milwaukee, WI 53201-2906

Fax: 1-262-834-3589

1: Member Details							
Title: Mr. Mrs. Ms. Miss							
First Name:	Midle Initial:	Last Name:					
Date of birth (mm/dd/yyyy):		Gender: Male Female					
ID number (as shown on your member ID card, 6 or 8 digits):							
Policy number (as shown on your member ID card):							
Member's full address:			Apt #:				
City:		State:	Zip Code:				
Daytime Phone:							
Evening Phone:							
Email:							

2. Provider Information								
2. Flovider illioritation								
Name of dental pr	actitioner:							
Provider NPI/TIN r	number:							
Location of service	Suite:							
City:			State:	Zip Code:				
Daytime Phone:			I					
Fax:								
3: Invoice Infor	mation							
Fill in the details of	each invoice being	submitted with this claim:						
Date of Service (mm/dd/yyyy)	Invoice Date	Service Rendered by Provider/Service Detail (i.e., Root Canal, Cleaning, Restoration, Dentures)		Procedure Code	Invoice Amount			