



Insurance Company, Inc.

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:		

