Dental Reimbursement Form

Your 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, please submit the following:

- ☐ Reimbursement form
- ☐ Your itemized receipt(s)

Please submit these items to:

DentaQuest Claims
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 1-262-834-3589

1. Member Details		
First Name:	Middle Initial:	Last Name
Date of Birth (mm/dd/yyyy): _ _/_ _/_ _ _ _		
Name of Insurer:		
ID number (as shown on your member ID card):		
Policy number (as shown on your member ID card):		

2. Contact Information		
Street Address:		Apt:
City:	State:	Zip code:
Daytime phone: (_ _ _) _ _ _ -_ _ _ _	Evening phone: (_ _ _) _ _ _ -_ _ _ _	
Email:		

3. Provider Information		
Name of Provider:		Provider NPI/TIN
Name of Provider Office:		
Address:		Suite:
City:	State:	Zip code:
Daytime phone: (_ _ _) _ _ _ -_ _ _ _	Fax: (_ _ _) _ _ _ -_ _ _ _	

4. Invoice Information				
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