

# Dental Reimbursement Form

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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

<b>1. Member Details</b>		
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):		
<b>2. Contact Information</b>		
Street Address:		Apt:
City:	State:	Zip code:
Daytime phone: ( _ _ _ ) _ _ _ - _ _ _ _	Evening phone: ( _ _ _ ) _ _ _ - _ _ _ _	
Email:		

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

<b>4. Invoice Information</b>				
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