Clever Care HEALTH PLAN | DentaQuest a Sun Life company

Dental Reimbursement Form

Your plan covers dental services from licensed dentists within your service area up to your quarterly allowance amount. Refer to your Evidence of Coverage for more information. **To receive reimbursement, submit this form along with your itemized receipt and proof of payment to:**

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

1. Member Details

First Name:	Middle Initial:	Last Name:
Birth date: (MM/DD/YYYY)		
Name of Insurer: **Clever Care Health Plan**	Clever Care Member ID #:	

2. Contact Information

Street Address:		Apt:
City:	State: **CA**	ZIP code:
Telephone Number:	Email (optional):	

3. Provider Information

Name of Provider:		Provider NPI/TIN (optional):
Name of Provider Office:		
Address:		Suite:
City:	State: **CA**	ZIP code:
Telephone Number:	Fax:	

(Continued)

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4. Invoice Information

Fill in the details of each invoice being submitted with this claim.

Date of Service (MM/DD/YYYY)	**Invoice Date** (MM/DD/YYYY)	**Service Detail Rendered by Provider** (e.g.,Root Canal, Restoration, Dentures)	**Procedure Code**	**Amount Paid**