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 Nam	e				
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:	Eveni	Evening phone:					
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Email:							

3. Provider Information											
Name of Provider:				Provider NPI/TIN							
Name of Provider Office:											
Address:			Suite:								
City:				State:	State: Zip code:						
Daytime phone:			Fax:								
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4. Invoice Information											
Fill in the details of each invoice being submitted with this claim:											
Date of Service	Invoice Date	Service Rendered by					edure	Invoice			
(mm/dd/yyyy)		Detail (i.e., Root Canal, Cleaning,			Co	ode	Amount				
		Restoration, D	enture	s)							