

Dental Reimbursement Form

To request 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:
Date of Birth (mm/dd/yyyy):		
Name of Insurer:		
Member 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:
Telephone Number:		
Email (optional):		
3. Provider Information		
Name of Provider:	Provider NPI/TIN (optional):	
Name of Provider Office:		
Address:	Suite:	
City:	State:	Zip code:
Telephone Number:	Fax:	

