

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:		L	ast 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:					
Thanks of Frontier Since.					
Address:		Suite:			
Cit			Ct-t-		7: d
City:			State	:	Zip code:
Telephone Number:		Fax:			



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

		peing submitted with this claim:	1	
Date of Service (mm/dd/yyyy)	Invoice Date	Service Detail Rendered by Provider (i.e., Root Canal, Cleaning, Restoration, Dentures)	Procedure Amount Code Paid	