care@care
Insurance Company, Inc.

Dental Reimbursement Form

Our 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, you must submit the following:
1. Reimbursement form 2. Your itemized receipt(s) 3. Claim form (If provided by your dentist)

Please submit these items to:
DentaQuest Claims
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 1-262-834-3589

1: Member Details			
Title: □ Mr. □ Mrs. □ Ms. □ Miss			
First Name:	Midle Initial:	Last Name:	
Date of birth (mm/dd/yyyy):		Gender: □ Male □ Female	
ID number (as shown on your member ID card, 6 or 8 digits):			
Policy number (as shown on your member ID card):			
Member's full address:			Apt #:
City:		State:	Zip Code:
Daytime Phone:			
Evening Phone:			
Email:			

2. Provider Information		
Name of dental practitioner:		
Provider NPI/TIN number:		
Location of services rendered: Address:		Suite:
City:	State:	Zip Code:
Daytime Phone:		
Fax:		

3: Invoice Information				
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