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)

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