my choice WISCONSIN Health Plan

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 Name
Date of Birth (mm/dd/yyyy): _ _/_ _/_ _ _ _		
Name of Insurer:		
ID number (as shown on your member ID card, 6 or 8 digits):		
Policy number (as shown on your member ID card):		

2. Contact Information		
Street Address:		Apt:
City:	State:	Zip code:
Daytime phone: (_ _ _) _ _ _ -_ _ _ _	Evening phone: (_ _ _) _ _ _ -_ _ _ _	
Email:		

3. Provider Information			
Name of Provider:			Provider NPI/TIN
Name of Provider Office:			
Address:			Suite:
City:		State:	Zip code:
Daytime phone: (_ _ _) _ _ _ -_ _ _ _		Fax: (_ _ _) _ _ _ -_ _ _ _	

4. 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., Cleaning, Restoration, Dentures)	Procedure Code	Invoice Amount

5. Member Attestation

Please check if you are the: ☐ Member OR ☐ Beneficiary Representative

If you are the Beneficiary Representative, please attach the required Appointment of Representation (AOR),Power of Attorney, or Executor of Estate form. The AOR form can be found at:
https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207

By signing below, I attest that I have paid the dollar amount listed below for the services received while a Medicare Plan member. I further certify that the documents attached to this form demonstrating proof of payment are accurate, true, and complete in all respects.

_____ _____

Signature (Required) Date

_____ _____

Beneficiary Representative Signature Date

If you are signing as a Beneficiary Representative, we require both your signature and the member's signature.