



Dental Claim Member Reimbursement

This policy informs you of how you may get reimbursed for dental services provided by DentaQuest.

Please submit the following information within 365 days of the date of service:

1. a copy of your proof of payment; **and**
2. an itemized list of services provided by your dentist

Please ensure your information is written legibly on each piece of documentation and should include:

- Your first name
- Your last name
- Your date of birth
- Blue Medicare Advantage ID Number.
 - *Include the first 3 letters, in addition to the nine (9) digits).*
 - *For example: RKN123456789*
- *If not already on your itemized list:*
 - Dentist Name
 - Dentist Address
 - Dentist phone number

If this information is not provided at the time of request, your request may be denied after two attempts to contact the dentist for additional information.



FAX: 1-262-834-3589

MAIL:

DentaQuest
ATTN: Claims/Direct Member Request
PO BOX 2906
Milwaukee, WI 53201-2906

Services will be considered in accordance to the provisions outlined in your Evidence of Coverage, up to any limits of the benefit. Any service rendered out of network are subject to the out-of-network contract fee. You may be responsible for services not covered, above the out-of-network contract fee, or services received beyond the limits of the benefit.