Dental Reimbursement Form

MASS ADVANTAGE

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:

- ☐ Reimbursement Form
- ☐ Your Itemized Receipt(s)
- ☐ Claim Form (If provided by your dentist)

Contact Information

Please submit these items to DentaQuest Claims, PO Box 2906, Milwaukee, WI 53201-2906 or fax to 1-262-834-3589.

1 Member Details

Title	First Name	Middle Initial	Last Name

Date of Birth (mm/dd/yyyy)	Gender: Male / Female

Mailing Address (include Apt. #)

City	State	Zip

Daytime Phone Number	Evening Phone Number

Email

Mass Advantage ID#	Policy Number

2 Provider Information

Name of Dental Practitioner	Provider NPI/TIN Number

Address of Services Rendered

City	State	Zip

Daytime Phone Number	Fax

3 Invoice Information

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

Date of Service	Invoice Date	Service Rendered by Provider/ Service Detail (i.e., Root Canal, Cleaning, Restoration, Dentures)	Procedure Code	Invoice Amount