

Clover Health

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:

- 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): ____ / ____ / _____		Gender: Male / Female
ID number (as shown on your Clover Health member ID card, 6 or 8 digits):		
Policy number (as shown on your Clover Health member ID card):		
Member's full address:		Apt.:
City:	State:	Zip code:
Daytime phone: (_____) _____ - _____		
Evening phone: (_____) _____ - _____		
Email: _____ @hotmail / @yahoo / @aol / @gmail / @msn / @outlook		

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