# Medicare Advantage
# Dental Receipt Reimbursement Form

Please use this form to send a claim for reimbursement of out-of-pocket costs for covered dental services. Mail the completed form with an itemized bill and receipt* to:

Healthplex, Inc.
Attention: Claims Department
P.O. Box 211672
Eagan, Minnesota 55121

*All paid receipts need the date of service, name of dental provider and amount paid. Cancelled checks are not allowed in place of a paid receipt. Please keep a copy of all documents for your records. Copies sent with your request will not be returned. You must send your claim to us within 12 months of the date you got the service.

## Section 1 – Member Information (please print)

Member Name: _____ Member ID Number: _____

Address: _____

Phone Number: _____

## Section 2 – Dental Provider Information (please print)

Dental Provider Name: _____

Dental Provider Address: _____

Dental Provider NPI: _____ Dental Provider Tax ID: _____

## Section 3 – Member Signature

To the best of my knowledge and belief, my statements in this reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses I spent during the applicable plan year. I certify these expenses have not been previously reimbursed in this current benefit plan year.

Signature: _____ Date: _____

If you have questions, call **855-973-2803** (TTY: **800-662-1220**) from 8 a.m. to 8 p.m., Monday through Friday.

Services provided by a dental provider or other practitioner who has been precluded by Medicare or debarred from receiving federal funds, except for emergency and urgently needed services, will not be covered.