MEMBER REIMBURSEMENT DENTAL CLAIM FORM

(For dental claims only - please complete one form per family member per provider)

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Instructions

1. You will need your dental care provider to assist and supply information in completing this form, including the CDT code(s) and diagnosis code(s). It is recommended that you bring it with you to your appointment. Please also refer to the FAQs on the back of this form for additional information.
2. To request reimbursement, please submit the following to the address listed at the bottom of this form (any missing information may result in delay or denial of the request):
   a. This completed and signed reimbursement form b. Proof of services rendered c. Proof of payment for the services being requested for reimbursement (include a copy of a detailed bill, preferably on an ADA form).
3. Most completed reimbursement requests are processed within 30 days. Incomplete requests may take longer.
4. Reimbursement will be sent to the plan subscriber (see FAQs for definition) at the address Envolve Benefit Options has on record.
5. Retain a copy of all receipts and documentation for your records.

Subscriber Information

Last Name:	First Name:	Middle Initial:

Patient Information

Ambetter Member ID#:	Last Name:	First Name:	Middle Initial:

Date of Birth (MM/DD/YYYY):	Mailing Address:

Telephone Number:	Patient Email Address:	Does Patient have additional insurance? Yes No	Did other Insurance make a payment: Yes No **(If yes, include plan's EOB)**

Other Insurance Company Name:	Other Insurance Company Phone Number:	Other Insurance Policy Number:

Claim Information

(This section must be completed and you will need your dental care provider to assist in completing this section.)

Dental Provider's Name:	Setting where treatment was received:	Telephone Number:	Provider NPI #:	Tax ID #:

Dental Provider's Address:	Were services received outside of the U.S.? Yes No

Detailed explanation of dental care service, including reason for service:

Date(s) of Service	CDT Codes (for each service provided)	Procedure Descriptions (e.g., x-ray, office visit, filling, etc.)	Amount Paid
			$
			$
			$
			$
		Total Amount Paid	$

Member signature is required _____

Envolve Benefit Options complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Envolve Benefit Options does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the plan subscriber and will contain information about the service (e.g., provider name, date, description of service).
I also understand that Envolve Benefit Options may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name _____ Signature _____ Date _____

Checklist

1. I have completed and signed this form in its entirety.
2. I have enclosed documents of Proof of Services received (see FAQs for an example of proof of payment).
3. I have enclosed documents of Payment of Services – not related to copay or plan deductible (see FAQs for an example of proof of payment).
4. I understand that most completed reimbursement requests are processed within 30 days. Incomplete requests may take longer.

Please submit this form and all documentation to:

Envolve Benefit Options • Claims Department-Member Reimbursement • P.O. Box 25656 • Tampa, FL 33622-5656

MEMBER REIMBURSEMENT DENTAL CLAIM FORM - Frequently Asked Questions (FAQs)

Question	Answer
What is this form used for?	This form is used to ask for payment for eligible dental care you have already received.
What is my responsibility?	Co-payments, deductibles, coinsurance, and non-covered services will be the patient's responsibility. If you receive care from an out-of-network provider and the provider bills more than the Usual, Reasonable, and Customary charge, the member will be responsible (i.e. balance billed) for the sum of the co-insurance amount and any amount that is over the Usual, Reasonable and Customary charge. **THIS IS NOT A GUARANTEE OF PAYMENT.** Actual payment for covered services will be paid at the appropriate level according to your plan benefits, and you may be billed for the difference between the Envolve allowed amount and the providers billed charges.
What if my service was completed out of the service area?	Depending on your plan type, copayments may apply for emergency care received in an emergency room. Routine or maintenance care is not covered outside the service area and will not be reimbursed unless pre-arranged with Envolve prior to receiving services.
What happens next?	After processing your claims, you will receive an Explanation of Benefits (EOB). The EOB explains the charges applied to your deductible (the fixed dollar amount you pay for covered services before the insurer starts to make payments) and any charges you may owe the provider. Please keep your EOB on file in case you need it in the future.
What else should I know?	You may receive a higher benefit if you use an Envolve provider.
Who should I contact if I need help with completing this form?	Contact Ambetter Member Services.
Field Name	**Description**
Subscriber Information	Subscriber is the person: Who enrolls in a plan and signs the membership application form on behalf of him/herself and any dependents; in whose name the premium is paid.
Patient's Ambetter Member ID#	ID# with suffix, found on the front of the Ambetter member ID card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits).
Provider's Name, Address, Telephone Number, NPI #, Provider Federal Tax ID #:	Detailed provider information (please contact your provider for this information).
In what setting did the patient receive treatment?	Such as dental office, emergency room, outpatient hospital (for x-rays, tests), inpatient hospital, and clinic.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment was written, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of the reason for the dental service.
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description. (e.g., x-ray, office visit, lab work, etc.)
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

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