P.O. Box 2548 | Detroit, MI 48202 | f: (313) 922-5700 | dencap.com

DENCAP Dental Plans - Dental Claim Reimbursement Form

SECTION A.) Office Information	Member Information
1. Office Name	5. Member Name
2. Office Address	6. Date of Birth
3. Office Phone	7. Member Address
4. Office Fax	8. Policyholder/Subscriber ID (SSN)

SECTION B.) Services Provided

	Procedure Date	Oral Cavity Area	Tooth Number	Tooth Surface	Procedure Code	Quantity	Description	Amt Pd.
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

SECTION C.) Treating Dentist Information

I have been informed of the treatment plan and associated fees, I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this form.

Patient/Guardian Signature: ______________________________ **Date:** ____________

I hereby authorized and direct payment of the dental benefits otherwise payable to me, directly to the below name's dentist entity.

Subscriber Signature: ______________________________ **Date:** ____________

32. Treating Dentist (Name of Provider Rendering Services)	33a. Dentist NPI	35. License Number

Please mail your Dental Claim Reimbursement Forms to:
DENCAP DENTAL PLANS
P.O. BOX 2548
DETROIT, MI. 48202

f5:V.11.06.19