Medicare Member Reimbursement Dental Claim Form

SUMMIT HEALTH

One form per member per provider.

Please print clearly, complete all applicable sections, attach copies of your bill and documentation of any payment you have made and sign this form.

Section 1 › Member information

Last name	First name	Middle initial

Member identification number	Group identification number

Street address	City	State	ZIP code

Phone number	Birthdate (mm/dd/yyyy)
(_____) _____	_____ / _____ / _____

Section 2 › Payment requested

The following information must be obtained from your provider or included on your itemized statement or bill from your provider. If the itemized statement includes the date of service and provider information, you do not need to complete those sections on the form. **Please send a copy of your statements or receipts. Do not send originals as they will not be returned to you.**

Date of service (mm/dd/yyyy) _____ / _____ / _____	Place of service

Procedure codes	Amount charged $

Section 3 › Provider information *(enter provider's billing address)*

Provider name			

Provider Tax ID	Provider NPI

Street address	City	State	ZIP code

Section 4 › Other insurance information

Is the member covered by another plan? ☐ Yes ☐ No	Name of other insurance company
Policy number	

If the other insurance made a payment, please include Explanation of Benefits.

Section 5 › Additional information

Condition was related to:	Member's employment? ☐ Yes ☐ No	Auto accident? ☐ Yes ☐ No	Other _____
Date of incident (mm/dd/yyyy): _____			

Foreign claims

For emergency or urgent services out of the country, please explain where services were provided (place of service) and explain the nature of the injury or illness.

Copies of billing or itemized statements and your proof of payment, are to be included in your request for reimbursement.

The proof of payment can be either a canceled check or a credit card statement, showing the currency exchange rates.

Place of service	Nature of injury or illness

Section 6 › Authorization (required)

I attest that the information above is true and accurate, and the services were received and paid for in the amount requested as indicated above.

Signature: _____ Date: ____ / ____ / _____

Please provide a copy of your receipt, a provider invoice or a statement that indicates the amount paid to the provider and method of payment, then mail this completed form along with your copy of payment.

Ready to submit? Mail this form to Summit Health:

Summit Health Plan, Inc. P.O. BOX 820070 Portland, OR 97282 FAX: 855-466-7208

Questions? Contact Summit Health Customer Service at 844-827-2355 (TDD/TTY 711).

YourSummitHealth.com