MEMBER REIMBURSEMENT DENTAL CLAIM FORM

envolve Benefit Options

STOP!

Before you proceed with this request, consult your Summary of Benefits. Only members with out-of-network benefit coverage will be considered for reimbursement. Please verify with your provider before you receive any services.

Instructions

1. Please complete one form per family member per provider.
2. Use this form for dental claims only.
3. You may need your healthcare provider to supply information for this form, including the CDT code(s) and diagnosis code(s). We suggest you bring this form with you to your appointment. Please refer to the Help Sheet for more information.
4. 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 (copy of a detailed bill, or superbill with provider's letterhead are preferred)
5. Most completed reimbursement requests process within 60 days.
6. Reimbursement will be sent to the address on record.
7. Keep a copy of all receipts and documents for your records.

Wellcare

- ☐ Alabama
- ☐ Arizona
- ☐ Florida
- ☐ Georgia
- ☐ Indiana
- ☐ Kansas
- ☐ Louisiana
- ☐ Massachusetts
- ☐ Maine
- ☐ Michigan
- ☐ Missouri
- ☐ Mississippi
- ☐ Nebraska
- ☐ Nevada
- ☐ New Hampshire
- ☐ New Jersey
- ☐ New Mexico
- ☐ North Carolina
- ☐ Ohio
- ☐ Oklahoma
- ☐ Oregon
- ☐ Pennsylvania
- ☐ South Carolina
- ☐ Tennessee
- ☐ Texas
- ☐ Washington

Ascension Complete

- ☐ Alabama
- ☐ Florida
- ☐ Kansas
- ☐ Illinois
- ☐ Indiana
- ☐ Michigan
- ☐ Tennessee
- ☐ Texas

Ambetter

- ☐ Arkansas
- ☐ Mississippi
- ☐ Oklahoma
- ☐ Texas

Other

- ☐ Texas Community First (Marketplace)

Please submit this form and all documentation to:
Envolve Benefit Options • Claims Department-Member Reimbursement • P.O. Box 23768 • Tampa, FL 33623-3768

MEMBER REIMBURSEMENT DENTAL CLAIM FORM

envolve Benefit Options

Instructions

Patient Member ID#:	Last Name:	First Name:	Middle Initial:	D.O.B. (MM/DD/YYYY):

Mailing Address (include city, state, and ZIP):

Telephone Number:	Does Patient have additional insurance? ☐ Yes ☐ No If yes, please attach primary plan's Explanation of Benefits (EOB).

Claim Information

(This section must be completed. Your Dental care provider may need to assist incompleting this section.)

Healthcare Provider Name:	Telephone Number:	Provider NPI #:	Tax ID #:

Healthcare Provider Address:

Healthcare Provider City, State, and ZIP Code:

Date(s) of Service	CDT Codes (for each service provided - if you are unsure, attach receipt copy)	Procedure Description (e.g., x-ray, office visit, exam, filling, etc.)	Amount Paid
			$
			$
			$
			$
		Total Amount Paid	$

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 canceled and I may be subject to criminal and/or civil penalties for false healthcare claims. I understand that reimbursement payment will be sent to the address on file 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 Member Name Member Signature Date

Checklist

- ☐ I have confirmed my plan benefit includes access to out-of-network providers.
- ☐ I have completed and signed this form in its entirety.
- ☐ I have enclosed documents of Proof of Services received (see the help sheet for an example of proof of services).
- ☐ I have enclosed documents that prove Payment of Services – not related to copay or plan deductible (see the help sheet for an example of proof of payment).
- ☐ I understand that most completed reimbursement requests are processed within 60 days. Incomplete requests may take longer.

Please submit this form and all documentation to:
Envolve Benefit Options • Claims Department-Member Reimbursement • P.O. Box 23768 • Tampa, FL 33623-3768

envolve
Benefit Options

MEMBER REIMBURSEMENT DENTAL CLAIM FORM - HELP SHEET/FAQs

Question	Answer
What is this form used for?	This form is used to ask for reimbursement of out of pocket expenses for eligible dental care performed by a provider who is not in the Envolve network of providers. **Only members with out-of-network benefit coverage will be considered for reimbursement.**
What is my responsibility?	Copayments, deductibles, coinsurance, and non-covered services will be patient 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 coinsurance amount and any amount that is over the Usual, Reasonable and Customary charge. **THIS IS NOT A GUARANTEE OF PAYMENT.** Actual payment for covered service will be paid at the appropriate level according to your plan benefits and you may be billed for the difference between Envolve allowed amount and the providers billed charges.
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.
Who should I call if I need help completing this form?	Call the Member Services number on your health plan member ID card.

Field Name	Description
Patient Member ID#	ID# with suffix, found on the front of the health plan member ID card.
Name	Last and First names and Middle Initial of patient who received services.
Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parent's.
Address, Telephone	Use residential address; no PO box, please. Include area code with telephone number.
Other Insurance Coverage	Choose yes or no for these questions.
Provider's Name, Address, Telephone Number, NPI #, Provider Federal Tax ID #	A provider includes, but is not limited to: hospitals, physicians, dentists, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers.
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, exam, filling 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

Please submit this form and all documentation to:
Envolve Benefit Options • Claims Department-Member Reimbursement • P.O. Box 23768 • Tampa, FL 33623-3768