AmeriHealth Caritas
VIP Care

Member Reimbursement Form for Dental Services

Instructions:

- If you have paid your provider for dental services, please consult with your dentist to complete this form in its entirety. If information is missing or incomplete, it will result in a delay in consideration of payment. Acknowledgement is required below by both you, and your dental provider. **NOTE:** Box 25 below should reflect the amount **you** paid out of pocket to your dental office **after** any discounts/adjustments.
- Please complete the form for all in-network provider visits. You should also use this form if you received plan prior approval or an exception to see an out-of-network provider.
- Completed forms are to be mailed to:

  SKYGEN
  P.O. Box 1294
  Milwaukee, WI 53201

Important Information: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PATIENT INFORMATION		
1. Patient Name (Last, First, Middle Initial, Suffix)		2. Phone Number
3. Address, City, State, Zip Code		
4. Date of Birth (MM/DD/YYYY)	5. Subscriber/Member ID (refer to your member ID card)	
6. Group Number	7. Name of Employer (if applicable)	
8. Do you have additional dental insurance? Yes/No – If **Yes**, complete the below (lines 9-12) and include a copy of the payment breakdown(s)/Explanation of Benefits (EOB) from your other insurance.		
9. Name of Other Dental Insurance	10. Policy Number	11. Group Number
12. Address, City, State, Zip Code		

DENTAL PROVIDER INFORMATION		
13. Dentist Name	14. Phone Number	
15. Address, City, State, Zip Code		
16. NPI Number	17. License Number	18. Tax ID Number

DENTAL SERVICES RECEIVED

	19. Date of Service (MM/DD /YYYY)	20. Area of Oral Cavity	21. Tooth Number(s) or Letter (s)	22. Tooth Surface	23. Procedure Code	24. Description	25. Amount **you** paid to dental office
1							
2							
3							
4							
5							
6							
7							
8							
9							

ACKNOWLEDGEMENT OF SERVICES AND PAYMENT
(Signatures are required as proof that services noted above have been rendered and paid in full)

Member Acknowledgement: I acknowledge that I received the dental services noted above, and have paid my dental provider in full. The amount(s) noted in Box 25 represents what I paid out of pocket to my dental office excluding any discounts/adjustments.

26. Member/Authorized Representative Signature	*27. Date*

Dental Provider Acknowledgement: I acknowledge that the service(s) noted above, have been rendered. In addition, that box 25 reflects the full payment made by the member less any discounts/adjustments.	
28. Dental Practice Representative Signature	*29. Date*

If you have any questions, please call Member Services at 1-844-964-4433 (**TTY/TDD users should call 711)** from **8 a.m. – 8 p.m., seven days a week.** After hours, on weekends, and on federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

AmeriHealth Caritas VIP Care is an HMO D-SNP plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to members. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-964-4433 (TTY 711)** de 8 a.m. a 8 p.m., los siete días de la semana. La llamada es gratuita.

تنويه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية لك مجانًا. يُرجى الاتصال بالرقم **1-844-964-4433 (TTY 711)**، من 8 صباحًا إلى 8 مساءً، سبعة أيام في الأسبوع. المكالمة مجانية.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-844-964-4433, 8 a.m. – 8 p.m., seven days a week. The call is free.

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