Out-of-Network Dental Reimbursement Form

HealthPartners Medicare Plans

- HealthPartners® Journey (PPO)
- HealthPartners® Robin (PPO)
- HealthPartners UnityPoint Health (PPO)
- HealthPartners® Freedom (Cost)
- HealthPartners® Retiree National Choice

When do I use this form?

Use this form if you're asking for reimbursement of a covered dental service that you paid to an out-of-network dentist.

How do I get my reimbursement?

- Complete this form and mail it or fax it to us along with the receipts and itemized bills.

  Mail:
  HealthPartners Dental Claims Dept.
  P.O. Box 1289
  Minneapolis, MN 55440-1289

  Fax: 651-265-1001

- Submit dated receipts and itemized bills showing the dental code or service description and charge for each code/service. Make copies of all of your receipts and itemized bills. All materials submitted will be retained by us and cannot be returned to you.
- You must submit this form within one year (12 months) of the date you received the service.
- HealthPartners will process your request. If your request is incomplete, we will let you know.

866-233-8734 (TTY 711)
8 a.m.–8 p.m. CT, Monday–Friday
(Oct. 1–March 31, seven days a week)

Out-of-Network Dental Reimbursement Form

Use this form to request a reimbursement for dental services covered by your HealthPartners Medicare plan. Reimbursement amounts may vary depending on plan coverage and the amount remaining of your dental benefit annual maximum.

Member information

Last name | First name | Middle initial

Member ID | Phone number

Dentist Information

Treating Dentist's Full Name		Dentist NPI	
Dental Clinic Name		Tax ID	
Street Address	City	State	Zip Code

Documentation needed

- This completed form. (Must submit within one year (12 months) of the date you received the service.)
- Submit copies of dated receipts and itemized bills showing the dental code or service description and charge for each code/service that you are requesting reimbursement.
- If the dentist's bill shows your payment, we can reimburse you directly. If it doesn't, please provide proof of payment (copy of canceled check, credit card receipt, etc.). Otherwise, we'll pay the approved amount directly to the dentist.

Certification

Agreement:
I certify that the information on this form is correct to the best of my knowledge. I am requesting reimbursement for eligible expenses as outlined in my plan's Evidence of Coverage or Group Certificate document.

Member's signature

_____

Date _____