Out-of-Network Member Reimbursement Form

Say Cheese Dental Network

The Out-of-Network Member Reimbursement Form is not a guarantee of payment. Say Cheese Dental Network reviews the coverage documents to ensure all provisions have been followed.

This form must be submitted within 90 days of the date of service to be considered for reimbursement. Benefits will be denied or reduced if submissions exceed 12 months of the date of service.

► **To ensure a faster claim review, please include the receipt of payment.**

To be completed by the Member

Member Name: _____

Member ID Number: _____

Date of Birth: _____

Date of Service: _____

To be completed by the Provider

**Please reach out to your provider for this information, or request your provider submit a claim directly to Say Cheese Dental Network for consideration.

Provider Name: _____

Tax Identification Number (TIN): _____

National Provider Identifier (NPI): _____

ADA Dental Code(s): _____

Next Steps

Please ensure you have the following documentation.

- Completed Member Reimbursement Form
- **Paid** receipt for all services
  Please note—In order to qualify for reimbursement, receipts must show a zero-dollar balance, meaning the service or item has been paid in full
- ADA Dental Claim Form indicating all services provided

Please mail this form to:

Member Reimbursement Claims
PO Box 644
Milwaukee, WI 53201

If you need assistance with this form or have any questions, please contact Say Cheese Dental Network at 888-454-4127 (TTY 711), Monday–Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m.

Member or Authorized Representative Signature

X	Date: