univera HEALTHCARE an excellus company

PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-4) OF THIS FORM

Please Note: COPIES OF ALL BILL/RECEIPTS FOR a Dental Cleaning or Exam MUST BE SUBMITTED WITH THIS FORM IN ORDER FOR YOUR REWARED TO BE CONSIDERED. if you do not have a valid bill or receipt for a Dental Cleaning or Exam, please contact the provider of service to obtain prior to submitting for your reward reimbursement.

NOTE: Please submit one rewards request per Univera Dental Reward form. Individual reward requests need to be submitted for each eligible dependent according to your contract. To be eligible for this reward benefit services must be for either a dental cleaning or exam.

If you have eligibility, benefit or form related questions, please contact your Account Services Representattives at 1-833-396-9355.

Univera Dental Rewards

Mail completed form and all required information to :

Univera Healthcare
P.O. Box 211256
Eagan, MN 55121-2656

SECTION 1
INFORMATION REQUIRED FOR REWARD

1-FULL NAME AND DATE OF BIRTH OF THE PERSON RECEIVING SERVICES

2-NAME AND ADDRESS OF THE DENTAL PROVIDER PROVIDING THE SERVICE

3-DATE SERVICE IS RENDERED

4-CHARGE FOR SERVICE RENDERED

5-ALL CLAIMS MUST BE SUBMITTED WITHIN 120 DAYS AFTER CLEANING AND EXAM IN ORDER TO BE CONSIDERED FOR REWARD PAYMENT.

SECTION 2
SUBSCRIBER INFORMATION

Please enter all information exactly as shown of your ID card.

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	SUBSCRIBER IDENTIFICATION NUMBER	
ADDRESS NUMBER AND STREET	CITY	STATE	ZIP CODE

SECTION 3
SERVICE INFORMATION

Please complete all sections below for each individual service rendered. If you need more than three sections, please complete a separate form. NOTE. Please select only the amount you are eligible for based on your contract benefits. ***If you don't know your benefit, contact your benefit administrator or call the telephone number listed on your identification card.***

PATIENT'S FULL NAME	MEMBER'S DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	DATE(S) OF SERVICE	FOR INTERNAL USE ONLY SERVICE INFORMATION	REWARD AMOUNT
LAST NAME: FIRST NAME:	____/____/_____ *mm dd yyyy*	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: ___/___/___	☑ DENTAL CLEANING AND EXAM *D0120* *Dx. Z7189* For Internal Use Only	$25 $50 $100

PLEASE NOTE: DO NOT ENTER ANY ADDITIONAL INFORMATION IN ANY OF THE BOXES ON THIS FORM

SECTION 4
SIGNATURE AND DATE

Unsigned forms will be returned

I CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THE EXPENSES INCURRED WERE FOR MYSELF, SPOUSE, OR QUALIFIED DEPENDENT(S).

SUBSCRIBER SIGNATURE: _____ **DATE:** _____

Dental Rewards Form Instructions

Please Note: COPIES OF ALL BILLS/RECEIPTS FOR Cleaning or Exam MUST BE SUBMITTED WITH THIS FORM IN ORDER FOR YOUR REWARD TO BE CONSIDERED. If you do not have a valid bill or receipt for Dental Cleaning or Exam, please contact the provider of service to obtain prior to submitting for your reward reimbursement.

NOTE: Please submit one reward request per Univera Dental Rewards form. Individual reward requests need to be submitted for each eligible dependent according to your contract. To be eligible for this reward benefit, services must be for either a dental cleaning or exam.

If you have eligibility, benefit or form related questions, please contact your Account Services Representative at 1-833-396-9355

1) **SECTION 1: INFORMATION REQUIRED FOR REWARD**
COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMTTED** WITH THIS FORM IN ORDER FOR YOUR REWARD TO BE CONSIDERED. BALANCE BILL, CANCELLED CHECKS ETC. ARE **NOT** ACCEPTABLE. BILLS MUST ***CLEARLY*** INDICATE **ALL OF THE FOLLOWING**:
1 – FULL NAME AND DATE OF BIRTH OF PERSON RECEIVING SERVICES
2 – NAME AND ADDRESS OF DENTAL PROVIDER PROVIDING THE SERVICES
3 – DATE SERVICE WAS RENDERED
4 – CHARGE FOR SERVICE RENDERED
5 – ALL CLAIMS MUST BE SUBMITTED WITHIN 120 DAYS AFTER CLEANING AND EXAM IN ORDER TO BE CONSIDERED FOR REWARDS PAYMENT

2) Section 2
Subscriber Information (Please enter all information exactly as shown on your ID Card
SUBSCRIBERS'S LAST NAME: Last Name of the Subscriber
SUBSCRIBER'S FIRST NAME: First Name of the Subscriber
SUBSCRIBER IDENTIFICATION NUMBER: Subscriber ID as it appears on your card
ADDRESS NUMBER AND STREET: Subscriber home address – please include apartment number if applicable
CITY: City in which your home address resides
STATE: State in which your home address resides
ZIP CODE: Zip Code in which your home address resides

3) Section 3
Service Information need to change the note next to it: Please complete all sections below for the individual service rendered. **Please submit only one reward request per Univera Dental Rewards form. Individual reward requests need to be submitted for each eligible dependent according to your contract. If you do not know your benefit, you can check your benefit by logging into www.univerahealthcare.com. Click on My Account from the main menu and then click on View Benefits and Coverage. Search for "Univera Dental Rewards". Or you can call your Account Services Representative at 1-833-396-9355**

LAST NAME: Last name of the person for whom the reward request is being submitted
FIRST NAME: First name of the person for whom the reward request is being requested

PATIENT DATE OF BIRTH: Birthdate for whom the reward is being requested in a mm/dd/yyyy format

RELATIONSHIP TO SUBSCRIBER: Relationship to the subscriber for the person for whom the reward is being requested

DATE of SERVICE: Date the service was provided

SERVICE INFORMATION: LEAVE BLANK – FOR INTERNAL USE ONLY

REWARD AMOUNT: Check the appropriate reward amount according to your benefit. **If you do not know your benefit, you can verify it by logging into www.univerahealthcare.com. Click on My Account from the main menu and then click on View Benefits and Coverage. Search for "Univera Dental Rewards". Or you can call your Account Services Representative at 1-833-396-9355**

PLEASE NOTE: DO NOT ENTER ANY ADDITIONAL INFORMATION IN ANY OF THE BOXES ON THIS FORM

4) **SECTION 4**

Please verify that all the information above is printed clearly and all of the boxes are appropriately filled out. Once confirmed, please sign and date below.

Mail Completed Form to:
Univera Healthcare
P.O. Box 211256
Eagan, MN 55121-2656