Delta Dental Reimbursement Request Form

Patient's Name: _____

Patient's Phone Number: _____

Patient's Address: _____

_____

Requested Reimbursement Amount: _____

(This is the total amount of money order or credit card receipt)

Send claim to:

Michael Lilya, Senior Account Manager
Delta Dental of Minnesota
500 Washington Avenue South, Suite 2060
Minneapolis, MN 55415
Fax: (612) 224-3211
mlilya@deltadentalmn.org

Reimbursement Request Checklist (Be sure to include all requested information)**:**

	No	Yes
1. **Delta Dental Reimbursement Request Form**	___	___
2. **Delta Dental Claim Forms** (Complete Patient Coverage Information Only)	___	___
3. **Copy of Money Order or Credit Card Receipt**	___	___
4. **Copy of Dental Lab Invoice**	___	___