univera HEALTHCARE an excellus company

Univera Dental Rewards

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

Please Note *If you do not have all of the required information please contact the provider of service for assistance prior to submitting your reward form. Failure to supply all of the required information may result in delayed processing and/or subsequent return of your reward submission.*

If your address has changed or is incorrect, please call our Customer Service Department at the telephone numbers listed on your identification card.

Mail completed form and all required information to :

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

SECTION 1
INFORMATION REQUIRED FOR REWARD

COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMITTED** 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 MEMBER RECEIVING SERVICES

2- NAME AND ADDRESS OF THE INDIVIDUAL OR BUSINESS/ORGANIZATION PROVIDING THE SERVICE(S)

3- DATE FOR **EACH** SERVICE RENDERED

4- CHARGE FOR **EACH** 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 on your ID card.*

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	INITIAL	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.***

SUBSCRIBER'S FULL NAME	MEMBER'S DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	DATE(S) OF SERVICE	SERVICE INFORMATION	REWARD AMOUNT
LAST NAME: ☐ FIRST NAME: ☐	/ / mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: / /	DENTAL EXAM AND CLEANING *D0120* *Dx. Z7189*	☐ $25 ☐ $50 ☐ $100
LAST NAME: ☐ FIRST NAME: ☐	/ / mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: / /	DENTAL EXAM AND CLEANING *D0120* *Dx. Z7189*	☐ $25 ☐ $50 ☐ $100
LAST NAME: ☐ FIRST NAME: ☐	/ / mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: / /	DENTAL EXAM AND CLEANING *D0120* *Dx. Z7189*	☐ $25 ☐ $50 ☐ $100

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:** ____________________