mint. Health Plans

Dental Reimbursement Claim Form

COMPLETE the following and attach itemized statements. (Cash register receipts cannot be accepted)

1.Employer/Group Name_____

2.Employee's name: Last_____ First: _____

3.Employee's mailing address: _____

City_____State_____ Zip_____

4.Phone number: _____

5.Patient's name: Last_____ First: _____

6. Does the patient have other health coverage: Yes_____ No_____

Name of other insurance company:_____

Policy number:_____ Effective date:_____

7.Payment for the attached claims should be made to: Employee_____ Provider_____

I authorize the release of any medical information necessary to process the claim and request payment of benefits to either myself or to the provider as stated above. I certify the above information to be true to the best of my knowledge. I also understand that any misrepresentation may be cause for dismissal and/or nonpayment of claims.

8. Employee signature:_____ Date:_____

Mail completed form
to: Mint Health Plans
PO Box 36 Smithfield UT 84335

You may also fax or email your claim as

follows:

Fax claims to: 435-563-4035
Email: claims@benefit-support.com