IMPERIAL HEALTH PLAN OF CALIFORNIA

Dental Reimbursement Request Form

Your plan covers dental services from licensed dentists within your service area up to an annual limit. Refer to your Evidence of Coverage for your plan's limit.

To receive reimbursement, please submit the following:

- Reimbursement form (Use of this form is not required, but all information must be submitted with your request to be processed)
- Your itemized paid receipt(s)

Please submit these items to:

Imperial Health Plan of California
PO BOX 60075
Pasadena, CA 91116

1. Member Details		
First Name:	Middle Initial:	Last Name
Date of Birth (mm/dd/yyyy): _ _/_ _/_ _ _ _		
Name of Insurer:		
ID number (as shown on your member ID card):		

2. Contact Information		
Street Address:		Apt:
City:	State:	Zip code:
Daytime phone: (_ _ _) _ _ _ -_ _ _ _	Evening phone: (_ _ _) _ _ _ -_ _ _ _	
Email:		

3. Dentist Information			
Name of Dentist:			Dentist NPI/TIN
Name of Dentist Office:			
Address:			Suite:
City:		State:	Zip code:
Daytime phone: (_ _ _) _ _ _ -_ _ _ _		Fax: (_ _ _) _ _ _ -_ _ _ _	

4. Invoice Information				
Fill in the details of each invoice being submitted with this claim:				
Date of Service (mm/dd/yyyy)	Invoice Date	Service Rendered by Dentist/Service Detail (i.e., Root Canal, Cleaning, Restoration, Dentures)	Procedure Code	Invoice Amount
EXAMPLE *12/24/2024*	*12/24/2024*	*Cleaning*	*D1110*	*$100*