



Preventive Dental Reimbursement Program

INSTRUCTIONS

1. Complete Section 1 - Patient Information
2. Complete Section 2 - Provider Information
3. Attach Original Receipts to this Form
4. Complete Section 4 - Subscriber Certification
5. Mail to Harvard Pilgrim Claims Processing

USE THIS FORM FOR HMO, POS, AND PPO HIGH OPTION PLANS THAT PROVIDE THE FOLLOWING DENTAL BENEFITS: Preventive care for children through the age of 12. Two visits per eligible dependent per calendar year including examination, cleaning, x-rays, and fluoride treatment. These benefits apply to all Primex³Health active high option plans.

SECTION 1 - PATIENT INFORMATION

(PATIENT NAME)		
LAST	FIRST	MIDDLE INITIAL
DATE OF BIRTH	PLAN ID NUMBER	
(SUBSCRIBER NAME)		
LAST	FIRST	MIDDLE INITIAL
MAILING ADDRESS		
CITY	STATE	ZIP
TELEPHONE (HOME) ()	TELEPHONE (WORK) ()	

SECTION 2 - PROVIDER INFORMATION

PROVIDER NAME
PROVIDER ADDRESS
PROVIDER TELEPHONE NUMBER
PROVIDER TAX ID NUMBER
DATE OF SERVICE

SECTION 3 - ORIGINAL RECEIPTS

PLEASE ATTACH ORIGINAL RECEIPTS TO THIS FORM

SECTION 4 - EMPLOYEE CERTIFICATION

I request reimbursement from the Primex³Health Preventive Dental Reimbursement Program for the expenses itemized on the attached receipts incurred during the plan year in which I was a current subscriber and the above dependent was a covered dependent. The expenses are in accordance with the terms and conditions as stated in the Schedule of Benefits and Benefit Handbook for Primex³ members.

SUBSCRIBER SIGNATURE: _____ DATE: _____

MAIL TO: Harvard Pilgrim Claims, P.O. Box 699183, Quincy, MA 02269-9183

For questions about completing this form, call Primex³Health at 1-800-698-2364.
For questions regarding plan benefits, contact Harvard Pilgrim customer service at 1-888-333-4742.