HealthTeam Advantage Member Reimbursement Request Form

Email form to: standard@argusdentalvision.com
Fax: 813-283-2457

Health Plan Representative Name:
Email:
Date Received by Health Plan:
Date Sent to Argus:

Member Information:

Member Name:
Member ID:
Member Mailing Address:
Preferred method of contact:

Provider Information:

Office Name:
Office Address:
Office Phone Number:
Tax ID#:
Treating Provider:
NPI#:

Items Requested for Reimbursement:

Date of Service	Procedure Code	Tooth/Area or Modifier	Amount Member Paid	Amount Argus to Pay Member

- **Member has 60 days from the Date of Service to submit a request for reimbursement.**
- **Argus claims department requires an itemized billing statement and proof of member payment to process Member Reimbursements. Please include all applicable documents in your request for Argus to process.**