Leech Lake Band of Ojibwe
Delta Dental Reimbursement Request Form

Patient's Name: _____

Patient's Phone: _____

Patient's Address: _____

Requested Reimbursement Amount: _____

(This is the total amount of money order or credit card receipt.)

Reimbursement Request Checklist:

Please include the following information before submitting your claim.

	NO	YES
1. Delta Dental Reimbursement Request Form	☐	☐
2. Delta Dental Claim Form *(Complete patient coverage information only.)*	☐	☐
3. Copy of Money Order or Credit Card Receipt	☐	☐
4. Copy of Dental Lab Invoice	☐	☐

Send Claim to:

Cindy Krech, Senior Account Manager
Delta Dental of Minnesota
500 Washington Avenue South, Suite 2060
Minneapolis, MN 55415

or Fax: 612.351.5171