Mail to:
Blue Benefit Administrators of MA
P.O. Box 55917
Boston, MA 02205-5917

Fax to:
877.596.2583

BLUE Benefit ADMINISTRATORS OF MASSACHUSETTS
An independent licensee of the Blue Cross and Blue Shield Association

Dental Claim Form

Please note: Each claim must be accompanied by an itemized bill from the facility or provider showing both procedure and diagnosis codes.

Employee Information

Last Name: First Name: Mid:

Street Address: Apt./Unit #

Birth Date: Marital Status:

City: State: Zip:

Home Phone: ( ) Alternate Phone: ( )

Email Address:

Employer Name:

Group Number (from Member ID Card):

Member Identification Number (from Member ID Card):

Patient Information

Last Name: First Name: Mid:

Street Address: Apt./Unit #

City: State: Zip:

Birth Date: **Patient's Sex:** Male ☐ Female ☐

Relationship to Participant: Self ☐ Spouse ☐ Child ☐ Other ☐

City: State: Zip:

Home Phone: ( ) Alternate Phone: ( )

Claim Information

Date of Service		Tooth # or Letter	Procedure Code	Description

Dentist's Information

Name of Billing Dentist: TIN: Dental License#

Address (City, State, Zip):

Phone Number:

If prosthesis, is this the initial placement? ☐ Yes ☐ No Date of prior placement:

Any reimbursement due should be made to: ☐ Member ☐ Provider

I certify that the above is complete and correct and that procedures, as indicated by date, have been completed. I have charged and intend to collect for those procedures.

Electronic Dentist's Signature **Date**