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

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: / / (month / day / year)	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: / / (month / day / year)	**Patient's Sex:** 0 Male 0 Female	
Relationship to Participant: 0 Self 0 Spouse 0 Child 0 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? 0 Yes 0 No Date of prior placement:		

Any reimbursement due should be made to: 0 Member 0 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.

Dentist's Signature _____ **Date** _____