



MASSACHUSETTS

DENTAL CLAIM FORM

Please contact your provider to confirm if they've already submitted or intend to submit a bill on your behalf.

Subscriber information

- 1. Submit a claim only when you're billed for services from a provider who doesn't directly submit a claim to the local Blue Cross Blue Shield plan.
- 2. Submit a separate form for each patient.
- 3. Attach an original itemized bill from your provider (required information and example on the back).

- 4. Keep a copy of all bills and claim forms submitted (originals will not be returned).
- 5. Be sure to sign and date the completed form.
- 6. Mail claim form and all attachments to"
 - BCBSMA
 - P.O. Box 986030
 - Boston, MA 02298

Identification number (including alpha prefix)	Last name	First name	Middle initial
Address – number and street	City	State	ZIP code
Date of birth (MM/DD/YY)			

Patient information

Patient last name	First name	Middle initial	Date of birth (MM/DD/YY)
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Patient is:

- Subscriber (contract holder) Spouse (of contract holder)
- Dependent (25 or under) Other (specify) _____

Does the patient have other insurance? Yes No

Effective date: (MM/DD/YY) _____

Other Blue Cross Blue Shield membership? Yes No _____

Other insurance plan? Yes No _____

Identification number: _____

Name and address of other insurance: _____

Was treatment for:

Accident at work? Yes No

Date of accident (MM/DD/YY) _____

Auto accident? Yes No

Date of accident (MM/DD/YY) _____

If yes, name of auto insurance: _____

Policy number: _____

Other accident? Yes No

Date of accident (MM/DD/YY) _____

Subscriber signature: _____	Date: (MM/DD/YY) _____
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Please allow up to 30 days for your claim to process.

Example of a complete itemized bill

Smith Dental
123 Main St.
Boston, MA 12345

To: Joe Smith
15 Elm St.
Anytown, MA 12345

Patient name: Joan Smith

NPI group provider: 9999999999
Treating provider NPI: 111111111

CDT code	Tooth	Procedure description	Date of service	Amount
D0120	N/A	Periodic oral evaluation	10/5/2022	\$72.50 ← Itemized charges
D2740	2	Crown – porcelain/ceramic substrate	11/3/2022	\$145.00
				Total: \$290.00
				Payments: \$290.00
				Balance due: \$0.00

Please note that your bill doesn't need to look exactly like the example above, but must contain the following required information:

- A letterhead from the provider that must include all of the following:
 - Provider's name
 - Provider's address
- Patient's name
- Date(s) of service
- Itemized charges for each date of service and type of service received
- CDT codes (dental codes) for all services received. Verify with your dental provider if there is any clinical documentation (Example: x-rays, periocharting) needed to be submitted with your claim
- Attach any related claim summaries or Explanation of Medicare Benefit forms you may have received for these services, including those received from other insurance companies.
- Dental services may require tooth number, surface/ quadrant or arch, based on services submitted. Your provider should indicate this on the itemized invoice.

To view processed claims, sign in to your MyBlue account. If you don't have a MyBlue account, create one at bluecrossma.org.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).
 ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).
 ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).