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) |
|---|---|---|---|
| | | | |

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) |
|---|---|
| | |

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: 1111111111**

| 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:**

1. A letterhead from the provider that must include all of the following:
   - Provider's name
   - Provider's address
2. Patient's name
3. Date(s) of service
4. Itemized charges for each date of service and type of service received
5. 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
6. 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.
7. 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**.