Dental Blue®
The right choice

Enhanced Dental Benefit Enrollment Form

Dear Physician:

This is an application for your patient to receive Blue Cross Blue Shield of Massachusetts Enhanced Dental Benefits. These Enhanced Benefits will provide additional preventive and periodontal benefits* to this dental member if they have been diagnosed with diabetes or coronary artery disease, or are pregnant. Please indicate if your patient has one of the medical conditions listed below that would allow him/her to access these Enhanced Dental Benefits. (Please note: Your patient's dental coverage policy must include Enhanced Dental Benefits in order to be eligible for coverage.) Thank you.

Please check condition:

Diabetes ______ Coronary Artery Disease ______

Pregnancy ______ Please include expected date of birth ______

Subscriber Name ______________________________

Member Name ______________________________ Date of Birth ______________

Member Address ______________________________

City ______________________ State ________ Zip Code ______________

Member Telephone # (h) ______________________ (w) ______________________

Blue Cross Blue Shield of Massachusetts Dental Identification Number ______________________

I hereby affirm that my patient has been diagnosed with the condition listed above:

Physician Signature ______________________________ Date ______________

Physician Name ______________________ MD/DO License # ______________ State ____
(please print)

Physician Address ______________________ Physician Telephone # ______________________

Please complete and keep a copy for your records. Please return this form to:

Enhanced Dental Benefits Program
Blue Cross Blue Shield of Massachusetts
Dental Operations
P.O. Box 986040
Boston, MA 02298

MASSACHUSETTS

*Periodontal maintenance and scaling available on plans that offer periodontal benefits.

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