MASSACHUSETTS

Dental Blue®
The right choice
Comprehensive Coverage from Blue Cross Blue Shield of Massachusetts

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 benefits to this dental member if they have been diagnosed with diabetes, oral cancer, 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** ☐ **Oral Cancer** ☐ **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 ID #	
I hereby affirm that my patient has been diagnosed with the condition listed above: Physician Signature		Date
Physician Name (please print) MD/DO	License #	State
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

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