MASSACHUSETTS | Dental Blue® The right choice

Enhanced Dental Benefits Enrollment Form

Dear Physician:

This is an application for your patient to receive Enhanced Dental Benefits from Blue Cross Blue Shield of Massachusetts. These Enhanced Dental Benefits will provide coverage for additional preventive services to this Dental Blue® member if they've been diagnosed with one or more of the qualifying medical conditions listed below. Please complete this form for your patient to receive Enhanced Dental Benefits. Thank you.

(Note: Your patient's dental coverage policy must include Enhanced Dental Benefits in order to be eligible for coverage).

Please check conditions:

☐ Diabetes ☐ Coronary Artery Disease ☐ Stroke* ☐ Oral Cancer ☐ Sjogren's Syndrome*

☐ Pregnancy (Expected date of birth_____/_____/_____)

Subscriber Name		
Member Name		Date of Birth
Member Address		
City	State	Zip Code
Member Telephone # (Home)	Member Telephone # (Work)	
Blue Cross Blue Shield of Massachusetts Dental ID #		
I hereby confirm that my patient has been diagnosed with the conditions listed above: Physician Signature: _____		Date
Physician Name (please print) MD/DO	License #	State
Physician Address	Physician Telephone #	

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

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

*Stroke and Sjogren's Syndrome are conditions being added to benefits on renewal starting 9/1/2019.

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