



MASSACHUSETTS Dental Claim Form

Pay Subscriber
BCS Pay Subscriber

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
Statement of Actual Services
Request for Predetermination/Preauthorization
EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage?
No (Skip 5-11)
Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)
7. Gender
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
19. Student Status
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

Table with columns: 24. Procedure Date, 25. Area of Oral Cavity, 26. Tooth System, 27. Tooth Number(s) or Letter(s), 28. Tooth Surface, 29. Procedure Code, 30. Description, 31. Fee

MISSING TEETH INFORMATION

Table for missing teeth with columns for Permanent and Primary teeth, and 32. Other Fee(s), 33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan...
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment
39. Number of Enclosures (00 to 99)
40. Is Treatment for Orthodontics?
41. Date of Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis?
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48 Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number
52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by the date are in progress (for procedures that require multiple visits) or have been completed.
54. NPI
55. License Number
56. Address, City, State, Zip Code
56A. Provider Specialty Code
57. Phone Number
58. Additional Provider ID

## HOW TO FILE A CLAIM

1. Complete Section I.
2. Ask your dentist to complete Sections 2 and 3, and sign the claim form;  
or attach an original itemized superbill.
3. All bills must include the following:

Letterhead bill

Patient's Name

Date(s) of Service

Charge for Each Service

Description and Procedure Code of Each Service

Tooth Number and Surface

Dentist's Social Security Number, Tax Identification Number or NPI

4. Send completed claim form to:

Blue Cross and Blue Shield of Massachusetts

P.O. Box 986030

Boston MA 02298

NOTE: Subscriber submit claims must be submitted within two years of the date of service.

Claims with incomplete information will be returned to the subscriber.

## HOW TO REACH US

Call: Please call the phone # on the front of your BCBS ID card.

Telecommunications Device

For the Deaf Service Number: 617-246-6525 or 800-522-1254

Write: Member Service

Blue Cross Blue Shield of Massachusetts

P.O. Box 9134

N. Quincy, MA 02171-9139