# Dental Blue
## *Enhanced Dental Benefits*

### Enhanced Dental Benefits

Additional Support for members with Qualifying Conditions

The connection is clear, good oral health leads to better overall health.

| Condition | One cleaning or periodontal maintenance, 4 per calendar year[1] | Periodontal scaling, once per quadrant every 24 months[1] | Oral cancer screening, twice per calendar year | Fluoride treatment, 4 per calendar year |
|---|---|---|---|---|
| DIABETES | ✓ | ✓ | | |
| CORONARY ARTERY DISEASE | ✓ | ✓ | | |
| STROKE | ✓ | ✓ | | |
| PREGNANCY | ✓ | ✓ | | |
| ORAL CANCER | ✓ | | ✓ | ✓ |
| SJÖGREN'S SYNDROME | ✓ | | ✓ | ✓ |
| INTELLECTUAL AND/ OR DEVELOPMENTAL DISABILITIES ← *NEW!* On plan renewal date | ✓ | | ✓ | ✓ |
| MENTAL HEALTH CONDITIONS ← *NEW!* On plan renewal date | ✓ | | ✓ | ✓ |

## NO ADDITIONAL COST TO RECEIVE THESE EXTRA SERVICES

Enhanced Dental Benefits are included with your dental coverage, at no additional cost. These services aren't subject to a deductible, co-insurance, or annual maximum when provided by a dentist in our network. If you have a PPO plan and choose to receive services from a dentist not in our network, you may be subject to co-insurance.

### SELF-ENROLLMENT FORM

MASSACHUSETTS

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 diagnosed with one or more of the qualifying medical conditions listed below. Please complete this form so that your patient may 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 qualifying medical conditions:

❑ Diabetes ❑ Coronary Artery Disease ❑ Stroke ❑ Oral Cancer ❑ Sjögren's Syndrome

❑ Pregnancy (Expected date of birth ___/___/___)

Subscriber/Member Information

Subscriber Name | Member Name | Date of Birth ___/___/___

Member Address | City | State | ZIP Code

Member Telephone # (Home) | Member Telephone # (Other)

Blue Cross Blue Shield of Massachusetts Dental ID #

Physician Information

I hereby confirm that my patient has been diagnosed with the conditions listed above. | Date ___/___/___

Physician Signature

Physician Name (please print, circle MD or DO) MD/DO | License # | State

Physician Address | Physician Telephone #

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

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

- Find form **online**: bluecrossma.org click on "Learn & Save" then "Fast Forms" for the "**Enhanced Dental Benefit Self Enrollment Form**"
- Or **call** us for a form**:** toll-free Team Blue telephone number on your Dental Blue ID card

Simmons UNIVERSITY