DELTA DENTAL®

Delta Dental of Massachusetts Enhanced Benefits Attestation Form

Welcome to Delta Dental of Massachusetts. This confidential form, when submitted to Delta Dental of Massachusetts, may enable you to take advantage of extra dental cleanings (up to a total of 4 annually) when you have certain medical conditions.

Follow these steps to complete and submit the form electronically.

1. Enter your information into the required fillable sections.
2. Save the form to your computer.
3. Send the form as an attachment file by email to: **EnhancedBenefits@deltadentalma.com**

Subscriber First Name	
Subscriber Last Name	
Subscriber ID or SSN (no dashes)	
Subscriber DOB (mm/dd/yyyy)	
Telephone Number	
Email	
Employer Name	
Employer Group Number	

Member Information (if qualifying member is not the subscriber)

Member First Name	
Member Last Name	
Member DOB (mm/dd/yyyy)	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Dependent

Please indicate below which of the following medical conditions you are experiencing. Check all that apply.
Superscript coding is for internal purposes only. All information is kept strictly confidential.

☐ Diabetes[13]	☐ Sjogren's syndrome[15]	☐ Chronic kidney disease[15]	☐ ALS[15]
☐ Heart disease[13]	☐ Parkinson's disease[15]	☐ Organ transplants[15]	☐ Opioid misuse and addiction[16]
☐ Stroke[13]	☐ Huntington's disease[15]	☐ Rheumatoid arthritis[15]	
☐ Radiation for head or neck cancers[15]	☐ *Pregnancy[14]	☐ Lupus[15]	

*Please indicate estimated due date (mm/dd/yyyy): _____

I certify that I (or my dependent) have one or more of the conditions listed above and am eligible for this enhanced coverage. I understand that submission of this form does not guarantee payment and that plan maximums, limitations and exclusions may apply. I also verify that the above information is true, current, and accurate, and agree that Delta Dental may verify this information as recorded on the health history records retained by the attending dentist.

Subscriber/Member Signature _____ Date _____
Electronic signature accepted. (mm/dd/yyyy)

If you are unable to complete this form electronically please print, fill and send the form to our mailing address or fax to 617-886-1293.

Mailing Address
Delta Dental of Massachusetts
Attn: Enrollment Department
465 Medford Street, Boston, MA 02129

QUESTIONS? Please call us at **877-335-8227.**