

**Mail to:**  
 CBA Blue  
 P.O. Box 2365  
 South Burlington, VT 05407-2365  
 Fax to: (802) 864-8115  
**Electronic Submission:**  
<https://secure.cbabluevt.com/>



## Dental Claim Form

Employee Information					
Last Name:		First Name:		Mid:	
Street Address:			Apt./Unit #		
Birth Date: / / <small>month day year</small>		Marital Status:			
City:		State:		Zip:	
Home Phone: ( )		Alternate Phone: ( )			
Email Address:					
Employer Name:					
Group Number (from Member ID Card):					
Member Identification Number (from Member ID Card):					
Patient Information					
Last Name:		First Name:		Mid:	
Street Address:			Apt./Unit #		
City:		State:		Zip:	
Birth Date: / / <small>month day year</small>		Patient's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Relationship to Participant: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
City:		State:		Zip:	
Home Phone: ( )		Alternate Phone: ( )			
Claim Information					
Date of Service	Tooth # or Letter	Procedure Code	Description	Fee	Notes
Dentist's Information					
Name of Billing Dentist:		TIN:		Dental License#	
Address (City, State, Zip):					
Phone Number:					
If prosthesis, is this the initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of prior placement:	

Any reimbursement due should be made to:  Member  Provider

I certify that the above is complete and correct and that procedures, as indicated by date, have been completed. I have charged and intend to collect for those procedures.

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_