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

Dental Claim Form

Please note: Each claim must be accompanied by an itemized bill from the facility or provider showing both procedure and diagnosis codes.

Employee Information

Last Name: First Name: Mid:

Street Address: Apt./Unit #

Birth Date: / / Marital Status:
month day year

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: / / Patient's Sex: 0 Male 0 Female
month day year

Relationship to Participant: 0 Self 0 Spouse 0 Child 0 Other

City: State: Zip:

Home Phone: ( ) Alternate Phone: ( )

Claim Information

	Date of Service	Tooth # or Letter	Procedure Code	Description	Fee

Dentist's Information

Name of Billing Dentist: TIN: Dental License#

Address (City, State, Zip):

Phone Number:

If prosthesis, is this the initial placement? 0 Yes 0 No Date of prior placement:

Any reimbursement due should be made to: 0 Member 0 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** _____