Capital Blue Cross Dental
Enhanced dental benefits self-reporting form

When to use this form

Oral health is a fundamental component of overall health and well-being. Members who care for and improve their oral health can positively impact their whole-body health.

Capital Blue Cross offers enhanced dental benefits for members with certain chronic health conditions.* Use this form to self-submit eligibility based on diagnosis if Capital Blue Cross does not have diagnosis eligibility on file from medical claims history.

Note: Please access this form through your member portal at **CapitalBlueCross.com** to submit form electronically for faster submission. **Please provide all requested information on this form. Incomplete forms will not be accepted and will be voided.**

What you'll need

- Patient name and address.
- Patient ID number from ID card.
- Patient group number from ID card.
- Treating physician name and phone number.

How to submit the form

Mail to: Capital Blue Cross, PO Box 772402, Harrisburg, PA 17177-2402

Email to: CBC.DocumentPrepUnit@CapBlueCross.com

Fax to: 717.541.6072

Questions

If you have questions about this form or your benefits, please call the dental Member Services number on the back of your ID card.

*Coverage for enhanced dental benefits is an optional benefit that may not be included in your plan. Consult your Benefits Booklet for benefits details.

Patient information					
Last name		First name		Middle initial	
Street address					
City		State		ZIP Code	
Date of birth (MM/DD/YYYY)		Group number			
ID number (11 numeric digit from ID card)	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___				

Relationship to subscriber

☐ Self. ☐ Spouse or domestic partner. ☐ Child or dependent.

Subscriber information (if the patient and subscriber are the same person, skip this section)					
Last name		First name		Middle initial	
Street address					
City		State		ZIP Code	
Date of birth (MM/DD/YYYY)					

Please check all applicable medical conditions in which you are actively being treated for by a physician.

☐ I have diabetes.
☐ I have cerebrovascular disease (CVD).
☐ I have end stage renal disease (ESRD).
☐ I have rheumatoid arthritis.
☐ I am pregnant, and my expected due date is: (MM/DD/YYYY)
☐ I have coronary artery disease (CAD).
☐ I have head/neck cancer.
☐ I am an organ transplant patient.
☐ I have oral cancer.
☐ I have lupus.

Treating physician			
Last name		First name	
Middle initial		Phone number	

To the best of my knowledge and belief, I am being treated for the condition or conditions noted above and with my below signature will provide proof of such condition if requested by Capital Blue Cross Dental. Additionally, upon request, I will provide a written authorization to Capital to obtain medical records from my provider(s). If such condition cannot be verified, I will not be eligible for additional dental benefits that may otherwise be available.

Signature		Today's date (MM/DD/YYYY)	

Questions? | Just call the dental Member Services number on the back of your Capital Blue Cross ID card.