Print Clear form

MASSACHUSETTS

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REQUEST FOR DENTAL CLAIM REVIEW

Please complete all required fields. Incomplete forms will not be processed.

Mail this completed form and supporting documentation (x-ray, narrative, chart, EOB, etc.) to:

Blue Cross Blue Shield of MA
Process Control
PO Box 986010
Boston, MA 02298

Today's date (MM/DD/YY): _____

PROVIDER INFORMATION			
*Provider name:		*Contact name:	
*NPI/TIN:		*Contact phone:	
*Address:			

MEMBER & CLAIM INFORMATION			
*Member name:		*Claim number:	
*Blue Cross ID # with prefix:		*Denial code:	
*Date(s) of service (MM/DD/YY):			

REVIEW TYPE	
Enter an X in one box only. Specify the purpose of the review submission where indicated.	
	Coordination of Benefits: The requested review is for a claim that processed as primary and did not coordinate benefits (EOB was attached).
	Corrected claim: The previously processed claim (paid or denied) requires an attribute correction (tooth identifier, procedure code, date of service, total charge, seat date, etc.). Please specify the correction: _____
	Duplicate claim: The original reason for denial was due to a duplicate claim submission.
	Filing limit: The original reason for denial was untimely filing. (Attach proof of prior submission)
	Request for Additional Information: The requested review is in response to a claim that was originally denied due to missing or incomplete information.
	Retraction of Payment: The provider is requesting a retraction of entire payment or service line (for example, not your patient, service not performed, etc.).
	Other:

COMMENTS	