MEMBER CLAIM FORM

(please complete one form per provider)

MASS ADVANTAGE
A Medicare Advantage Plan

INSTRUCTIONS

1. You may need your dental provider to assist and supply information in completing this form, including the procedure code(s). Please also refer to the member claim form help sheet for additional information.
2. To request reimbursement for dental services provided, please submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the request):
   a. This completed and signed claim form.
   b. Proof of services rendered.
   c. Proof of payment for the services being requested for reimbursement.
3. Reimbursement will be sent to the member at the address **Mass Advantage** has on record. If you believe your address is different than the address of record, please call Member Services at **(844) 918-0114**, TTY: 711 for HMO Members and **(844) 915-0234**, TTY: 711) for PPO Members. From October 1st to March 31st, we're available 7 days a week from 8 am to 8 pm EST. From April 1st to September 30th, we're available Monday through Friday from 8 am to 8pm EST.
4. Retain a copy of all receipts and documentation for your records.

MEMBER INFORMATION

Member ID #:	Date of Birth (MM/DD/YYYY):	
Last Name:	First Name:	Middle Initial:

CLAIM INFORMATION

Dental Provider's Name:	Setting Where Treatment Was Received:	Phone Number:	Tax ID Number or National Provider Identifier (NPI):
Address of Dental Provider:		Were services received outside of the U.S.? No, proceed to the next section Yes, answer the following questions: In what country was the patient seen? In what language was the bill written? In what currency was the bill paid?	

Date(s) of Service	Procedure Codes for Each Service Provided (if known)	Procedure Descriptions (e.g., office visit, dental cleaning, dental X-rays)	Tooth Number (if known)	Amount Paid
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$

Total amount paid $

Attach another sheet if more services are reported.

Member or personal representative signature is required.

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be canceled, and I may be subject to criminal and/or civil penalties for false healthcare claims. I also understand that **Mass Advantage** may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name	Signature	Date

[redacted]

Please submit this form and all documentation by mail to:

Dominion National Attn: Mass Advantage
PO Box 211424
Eagan, MN 55121

OR by fax to:

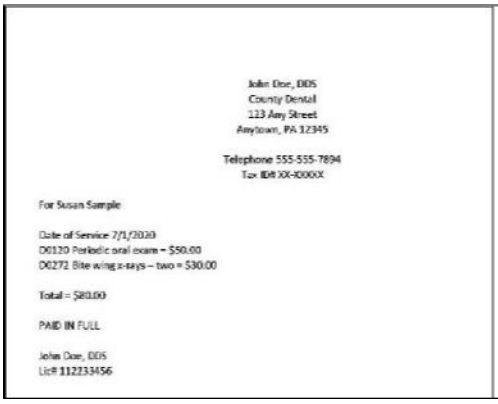
833-517-1939

Please note radiographs/x-rays should not be faxed as they will become non-diagnostic. Please send it by mail if your submission includes radiographs/x-rays.

MEMBER CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Member's ID #	**Mass Advantage** ID #, found on the front of the **Mass Advantage** ID card.
Member's Name	Last and first names and middle initial of member who received services.
Member's Date of Birth	Date of birth: MM/DD/YYYY
Provider's Name, Address, Telephone Number, Tax ID number, or National Provider Identifier (NPI)	Include Provider name. A dental provider includes, but is not limited to, general dentist, periodontist, and oral surgeon.
In what setting did the patient receive treatment?	Most dental services are received in an office.
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code (if known) and detailed description (e.g., office visit, dental cleaning, dental X-ray).
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: the front and back of the canceled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider on the provider's letterhead with authorized signature indicating payment was made; a receipt for purchased items with the provider's name and address preprinted on the receipt with items listed and amount paid.

PROOF OF SERVICE AND PROOF OF PAYMENT EXAMPLES



This example demonstrates both proof of payment and proof of service.

This example demonstrates proof of payment.