



## HOW TO FILE A CLAIM

1. Complete boxes 1 – 23.
2. Please make sure box 15 contains your member number as it appears on your ID card. **Do not use your social security number in this box.**
3. Be sure to sign the authorization to release information in box 36.
4. Ask your dentist to complete boxes 24 – 58, or attach an original itemized billing from the dentist on his/her letterhead or approved ADA claim form that includes all information requested in boxes 24-58.
5. Attach all related Explanation of Benefits statements for other coverage if applicable.
6. Send completed claim form to:

Dental Claims Administrator  
PO Box 69436  
Harrisburg, PA 17106-9436

NOTE: Subscriber submitted claim forms must be submitted within 180 days of the date of service. Claims which cannot be identified due to incomplete subscriber information will be returned.

## HOW TO REACH US

Phone:                   • Members - (888) 223-4999  
                              • Providers - (888) 224-5213

Write:                   Dental Customer Service  
                              PO Box 69437  
                              Harrisburg, PA 17106-9437