An Independent Licensee of the Blue Cross and Blue Shield Association

Oral Health for Total Health℠
Enhanced Dental Benefits Enrollment Form

Dear HMSA Dental Member:

This is an application for enhanced dental benefits from your HMSA dental plan. This program will provide additional preventive and/or diagnostic services if you have been diagnosed with one of the qualifying conditions.

Please complete both the member and provider information sections on this form. You must sign and date the form. All information is required and must be provided to qualify for enrollment in the Oral Health for Total Health program. The completed application can be mailed to the address on the other page of the form.

Note: It may take up to a month for us to process your enrollment. Once your enrollment has been processed, you will receive a welcome letter in the mail.

How did you hear about Oral Health for Total Health benefits?

☐ Pregnancy Support Nurse ☐ Condition Case Manager ☐ Other ______________________

MEMBER INFORMATION

Please check the qualifying condition that you have:

☐ Diabetes ☐ Coronary Artery Disease ☐ Stroke ☐ Oral Cancer ☐ Sjögren's Syndrome ☐ Pregnancy ______ (expected delivery date)

Primary Policy Holder Name: ______________________

Enrolling Member Name: ______________________ Date of Birth: ______________________

Enrolling Member ID: ______________________

Member Address: ______________________

City: ______________________ State: ______________________ Zip Code: ______________________

Member Phone Number: (Home) ______________________ (Cell) ______________________

Member Email Address: ______________________

☐ I would like to receive electronic communication about the Oral Health for Total Health Program.

☐ I hereby affirm that I have been diagnosed with the condition(s) checked on the Member Information section of this form.

Member Signature: ______________________ Date: ______________________

PROVIDER INFORMATION

Physician Name (Please Print): ____________________

MD/DO License Number: ____________________ State: ____________

Physician Phone Number: ____________________

Physician Address: ____________________

City: ____________________ State: ________ Zip Code: __________

Please complete and keep a copy for your records.

Return this form to:

Enhanced Dental Benefits
HMSA Dental Operations
P.O. Box 1320
Honolulu, HI 96807-1320
Fax: (808) 538-8966

The information you have provided will be used exclusively to determine if you qualify for enhanced dental benefits and for future contact concerning the program.

Go to **hmsadental.com/find-a-dentist** to find a dentist in your network.

For information about HMSA's Oral Health for Total Health program or enhanced dental benefits, visit **hmsa.com/oralhealth** or call Customer Service at (808) 948-6440 or toll free at (800) 792-4672.

FOR INTERNAL USE ONLY:

Date Received: ____________________ CC: ____________ Date Entered in THDB: ____________

Notes: ____________________

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