Delta Dental of Massachusetts
Trading Partner Profile

Trading Partner Name_____Tax ID_____

Address_____

City_____State_____Zip_____

Business Contact Name_____

Phone No._____Email Address_____

Copy to email address (optional):_____

Technical Contact Name_____

Phone No._____Email Address_____

Copy to email address
(optional):_____

Please place an 'X' next to the transactions you want to submit or receive:

837D_____999 _____835_____

Trading Partner Type, (e.g. Dentist office, billing service, clearinghouse, other): _____

Will you be using a Clearinghouse? Yes_____No_____ Name: _____

Trading Partner Authorized Signature_____

Printed Name of Signer_____

Date_____

Telephone No._____

Email Address_____

For assistance or questions regarding this form please contact our EDI Team at EDITeam@greatdentalplans.com and a representative will contact you. You may return this form via email at EDITeam@greatdentalplans.com.