Print Form

Report Fraud–Form

If you have evidence that fraudulent activity may have occurred, please fill out this form and mail or fax.

Mail to:

Utilization Management
Delta Dental of Massachusetts
P O Box 9695
Boston, MA 02129

Fax to:
617-886-1488

Provide as much information as possible pertaining to your complaint. Failure to provide sufficient information or documentation may prevent or delay the investigation of your complaint.

Please complete this form as accurately as possible

(*Required fields)

Name of person registering complaint: _____

Relationship to the patient: _____

Patient's name: _____

Member identification #:
(located on dental ID card) _____

Patient's date of birth: _____

Your daytime phone number: _____

E-mail address: _____

Street: _____

City: _____ State: _____ Zip: _____

*Name of dental office: _____

*Provider office phone number: _____

*In your own words, describe in as much detail as possible, the details, of the incident including the date of the visits.

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Protecting our customers' personal information is very important to us. Visit www.deltadentalma.com/privacy.asp for more details