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.