DELTA DENTAL®

I_____, request that Delta Dental of Massachusetts communicate with me at the alternate address listed below. ***I am the (check one):*** *_____Subscriber _____Member (named on Subscriber's policy) ____Other (please specify)*

If an alternate address is needed for a dependant under the age of 18 please submit legal documentation. Dependants over 18 are required to sign their own forms.

Checks issued for visits to non-participating Dentists will continue to be mailed to the Subscriber's address. For a list of participating providers, please check our website www.deltadentalma.com*, or call Customer Service at 1-800-872-0500.*

Printed Name_____

Subscriber ID_____

Subscriber Name_____

Covered individuals for whom the alternate address should be used:

_____

_____

_____

Alternate contact address:

_____

_____

_____

Preferred Phone number: _____

Please sign and date:
I have read the above statement and attest that I require communication about my PHI by the alternate address indicated above.

_____ _____
Signature Date

Internal Use only:

Accepted ☐
Denied ☐
Form incomplete ☐

Name:_____

Department:_____

Date:_____