



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. Please allow 10 to 12 business days for your form to be evaluated and approved for enrollment. Once we have completed evaluation of your form, we will mail a welcome letter to you as confirmation that you have qualified for enrollment into the program.

How did you hear about Oral Health for Overall 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)

Subscriber Name: _____

Member Name: _____ Date of Birth: _____

HMSA Subscriber 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 number: (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 our enhanced dental benefits, visit hmsa.com/oralhealth or call Customer Service at (808) 948-6440 or toll free at (800) 792-4672.

<u>FOR INTERNAL USE ONLY:</u>		
Date Received: _____	CC: _____	Date Entered in THDB: _____
Notes: _____		