DELTA DENTAL®

ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION *
OR PAYMENT **

STAPLE X-RAYS TO FORM

One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME | 2. RELATIONSHIP TO EMPLOYEE: SELF SPOUSE CHILD OTHER | 3. SEX: M F | 4. IMPORTANT PATIENT BIRTHDATE: MO. DAY YEAR | 5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME: LAST FIRST MIDDLE INT.

IMPORTANT 7. EMPLOYEE SOCIAL SECURITY NUMBER

OR 1 _____
OR 2 _____
OR 3 _____
OR 4 _____
OR 5 _____
OR 6 _____

8. EMPLOYEE HOME ADDRESS

CITY, STATE ZIP

ZIP CODE

9. EMPLOYER (COMPANY) NAME AND ADDRESS

10. GROUP NUMBER

IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15

11. DELTA – COVERED EMPLOYEE BIRTH DATE: MO. DAY YEAR

12. SPOUSE NAME

13. SPOUSE BIRTHDATE: MO. DAY YEAR

14. NAME AND ADDRESS OF CARRIER

15. SPOUSE SOCIAL SECURITY NUMBER

DENTIST NAME

MAILING ADDRESS

CITY, STATE ZIP

DENTIST SOC. SEC. NO. OR FED. IDENT. NO. | DENTIST LICENSE | DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT: OFFICE OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY?

	NO	YES	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, ENTER REASON FOR REPLACEMENT

DATE OF PRIOR PLACEMENT

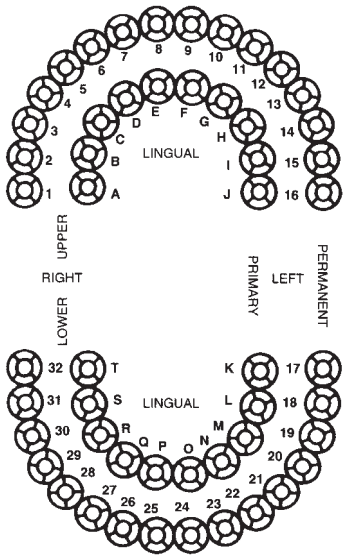
	NO	YES
IS TREATMENT FOR ORTHODONTICS?		

IF SERVICES ALREADY COMMENCED, ENTER:

DATE APPLIANCES PLACED

MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YR.	ADA PROCEDURE NUMBER	FEE
		1			
		2			
		3			
		4			
		5			
		6			
		7			
		8			
		9			
		10			
		11			
		12			
		13			
		14			
		15			
		16			
		17			
		18			
		19			
		20			
		21			
		22			
		23			

*** PREDETERMINATION OF COSTS**
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS.

DENTIST SIGNATURE DATE

**** TREATMENT COMPLETED – PAYMENT REQUESTED**
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.

DENTIST SIGNATURE DATE

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.

PATIENT SIGNATURE _____

DATE _____

TOTAL FEE CHARGED	
PATIENT PAYS	
DELTA PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

FORM DD/DC-0016-97-07