

**Delta Dental Claim Form**

See reverse for instructions



P.O. Box 9695  
Boston, MA 02114

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services Provider ID #		2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization # Patient ID #			3. Carrier name and address					
PATIENT COVERAGE INFORMATION	4. Patient name first _____ m.i. _____ last _____		5. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____		6. Sex m    f	7. Patient birthdate MM    DD    YYYY		8. If full time student school _____ city _____		
	9. Employee/subscriber name and mailing address		10. Employee/subscriber dental plan I.D. number	11. Employee/subscriber birthdate MM    DD    YYYY		12. Employer (company) name and address		13. Group number		
	14. Is patient covered by another dental plan yes    no If yes, complete 15-a. Is patient covered by a medical plan?    yes    no	15-a. Name and address of carrier(s)			15-b. Group no.(s)		16. Name and address of other employer(s)			
	17-a. Employee/subscriber name (if different from patient's)		17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate MM    DD    YYYY		18. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____				
19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.					20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.					
> Signed (Patient* - see reverse) _____ Date _____					> Signed (Employee/subscriber) _____ Date _____					
BILLING DENTIST	21. Name of Billing Dentist or Dental Entity				30. Is treatment result of occupational illness or injury?		No    Yes	If yes, enter brief description and dates		
	22. Address where payment should be remitted				31. Is treatment result of auto accident?		No    Yes	If yes, enter brief description and dates		
	23. City, State, Zip				32. Other accident?		No    Yes	If yes, enter brief description and dates		
	24. Dentist Soc. Sec. or T.I.N. (see reverse**)		25. Dentist license no.	26. Dentist phone no.		33. If prosthesis, is this initial placement?		No    Yes	(if no, reason for replacement)	34. Date of prior placement
	27. First visit date current series	28. Place of treatment Office    Hosp.    ECF    Other		29. Radiographs or models enclosed?	No    Yes	How many?	35. Is treatment for orthodontics?		No    Yes	If service already commenced enter:
Date appliances placed	Date	Mos. treatment remaining								
36. Identify missing teeth with "x"		37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.						For administrative use only		
		Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)		Date service performed Mo.    Day    Year		Procedure number	Fee	
38. Remarks for unusual services										
39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.							41. Total Fee Charged			
> Signed (Treating Dentist) _____ License Number _____ Date _____							42. Payment by other plan			
40. Address where treatment was performed							Max. Allowable			
City _____ State _____ Zip _____							Deductible			
							Carrier %			
							Carrier pays			
							Patient pays			