Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

2. Predetermination/Preauthorization Number

DELTA DENTAL®

P.O. Box 9695
Boston, MA 02114

Customer Service
800-872-0500

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐M ☐F	8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number	10. Patient's Relationship to Person Named in #5
	☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State. Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐M ☐F	15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number	17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber Named in #12 Above	19. Student Status
☐ Self ☐ Spouse ☐ Dependent ☐ Other	☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐M ☐F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								32. Other Fee(s)
12								
13								33. Total Fee

34. Remarks

AUTHORIZATIONS

35. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment of activities in connection with this claim.

X _____
Patient/Guardian signature Date

36. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

37. Place of Treatment	38. Number of Enclosures (00-99)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other	Radiograph(s) ☐ Oral Image(s) ☐ Model(s) ☐

39. Is Treatment for Orthodontics?	40. Date Appliance Placed (MM/DD/CCYY)
☐ No (Skip 40-41) ☐ Yes (Compete 40-41)	

41. Months of Treatment Remaining	42. Replacement of Prosthesis?	43. Date Prior Placement (MM/DD/CCYY)
	☐ No ☐ Yes (Complete 43)	

44. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

45. Date of Accident (MM/DD/CCYY)	46. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

47. Name, Address, City, State, Zip Code

48. NPI	49. License Number	50. SSN or TIN

51. Phone Number ( ) -	51A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

52. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

53. NPI	54. License Number

55. Address, City, State, Zip Code	56. Provider Specialty Code

57. Phone Number ( ) -	58. Additional Provider ID