

Delta Dental of Pennsylvania

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

SIGN BELOW  
FOR PREDETERMINATION \*  
OR PAYMENT \*\*  
STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15	1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER				3. SEX M F		4. 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.		7. EMPLOYEE SOCIAL SECURITY NUMBER										
8. EMPLOYEE HOME ADDRESS		9. EMPLOYER (COMPANY) NAME AND ADDRESS											
CITY, STATE ZIP		ZIP CODE											
10. GROUP NUMBER		IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15		11. DELTA - COVERED EMPLOYEE BIRTHDATE MO. DAY YEAR		12. SPOUSE NAME		13. SPOUSE BIRTHDATE MO. DAY YEAR		15. SPOUSE SOCIAL SECURITY NUMBER			
14. NAME AND ADDRESS OF CARRIER													

DENTIST NAME		IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
MAILING ADDRESS		IS TREATMENT RESULT OF AUTO ACCIDENT?					
CITY, STATE ZIP		OTHER ACCIDENT?					
DENTIST SOC. SEC. NO. OR FED. IDENT. NO.		DENTIST LICENSE		DENTIST PHONE NO.		IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
FIRST VISIT DATE CURRENT SERIES		PLACE OF TREATMENT OFFICE OTHER		RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		DATE OF PRIOR PLACEMENT IS TREATMENT FOR ORTHODONTICS? NO <input type="checkbox"/> YES <input type="checkbox"/>	
						IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING	

<p>IDENTIFY MISSING TEETH WITH "X"</p> <p>REMARKS FOR UNUSUAL SERVICES</p>	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						

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

<p>* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS</p> <p>DENTIST SIGNATURE _____ DATE _____</p>		<p>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.</p> <p>PATIENT SIGNATURE _____</p> <p>DATE _____</p>		TOTAL FEE CHARGED	
<p>** 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.</p> <p>DENTIST SIGNATURE _____ DATE _____</p>				PATIENT PAYS	
				DELTA PAYS	
				AMOUNT APPLIED TO DEDUCTIBLE	