DELTA DENTAL®

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Sacramento, California 95899-7330

Customer Service: 888-335-8227
www.deltadentalins.com

DELTA DENTAL OF CALIFORNIA ENCOURAGES DENTAL OFFICES TO SUBMIT CLAIMS ELECTRONICALLY.

1. PLEASE TYPE OR PRINT, 2. DO NOT USE A HIGHLIGHTER, 3. STAPLE X-RAYS TO TOP RIGHT CORNER

PLEASE MAKE SURE SUBSCRIBER'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME | 2. RELATIONSHIP TO SUBSCRIBER: SELF | SPOUSE | CHILD | OTHER | 3. SEX: M | F | **4. PATIENT BIRTHDATE** MONTH | DAY | YEAR | 5. IF FULL TIME STUDENT OVER 18, INDICATE: SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME: FIRST MIDDLE LAST | **7. SUBSCRIBER ID NUMBER** | 8. SUBSCRIBER BIRTHDATE MONTH | DAY | YEAR | 9. EMPLOYER (COMPANY) NAME AND ADDRESS/UNION LOCAL | 10. GROUP NUMBER

SUBSCRIBER MAILING ADDRESS | APT. NO. | PHONE NO.

CITY | STATE | ZIP CODE

11. DOES PATIENT HAVE COVERAGE THROUGH ANOTHER COMPANY? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES ☐ NO ☐ | 12A. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11. | 12B. GROUP NUMBER | 13. NAME AND ADDRESS OF EMPLOYER, ITEM 11

14A. SUBSCRIBER NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S) | **14B. SUBSCRIBER ID NUMBER** | 14C. SUBSCRIBER BIRTHDATE MONTH | DAY | YEAR | 15. RELATIONSHIP TO PATIENT: SELF | SPOUSE | CHILD | OTHER

16. DENTIST NAME | **LICENSE NUMBER**

17. MAILING ADDRESS

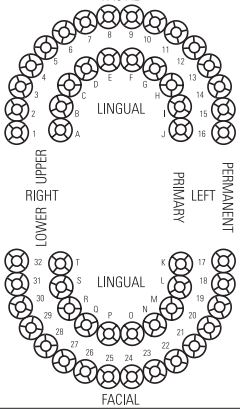
CITY, STATE, ZIP

18. DENTIST SOCIAL SECURITY NUMBER OR T.I.N. | 19. DENTIST LICENSE NUMBER | 20. DENTIST PHONE NUMBER

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT: OFFICE | HOSPITAL | ECF | OTHER | 23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY

	NO	YES	
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.
25. IS TREATMENT RESULT OF AN AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO ENTER REASON FOR REPLACEMENT.			29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER → DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



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

	TOOTH NO. OR LETTER	SUFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M	D	Y		PROCEDURE NUMBER	FEE	
1										
2										
3										
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32. REMARKS FOR UNUSUAL SERVICES OR **AMOUNT PAID BY OTHER COVERAGE** (ATTACH A COPY OF THE PRIMARY CARRIER'S EXPLANATION OF BENEFITS).

My dentist may give Delta Dental and any other carrier named above information about my dental condition or treatment needed to determine benefits for up to 5 years from the date.

Signature of patient (or parent or guardian) _____ Date _____

You may receive a copy of this authorization on request.

PRE-TREATMENT ESTIMATE

The treatment listed is necessary in my professional judgement, and I request a pre-treatment estimate.

Dentist Signature Date

TREATMENT COMPLETED – PAYMENT REQUESTED

The treatment listed was completed. I will charge and intend to collect the entire portion of the fees stated above that Delta Dental determines to be the patient's responsibility, and I will not waive, reduce or rebate any of that portion unless I expressly state on this form.

Dentist Signature Date

TOTAL FEE CHARGED	
PATIENT PAYS	
DELTA DENTAL PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

Delta 105 #49481 (rev. 9/08)