# DELTA DENTAL

Delta Dental of New York

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

## ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION *
OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE/SUBSCRIBER PLEASE PRINT

1. PATIENT NAME | 2. RELATIONSHIP TO EMPLOYEE: SELF SPOUSE CHILD OTHER | 3. SEX: M F | IMPORTANT 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. | IMPORTANT 7. EMPLOYEE SOCIAL SECURITY NUMBER | OR 1 OR 2 OR 3 OR 4 OR 5 OR 6

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

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?

IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES

IS TREATMENT RESULT OF AUTO ACCIDENT? NO YES

OTHER ACCIDENT? NO YES

IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO YES | IF NO, ENTER REASON FOR REPLACEMENT

DATE OF PRIOR PLACEMENT

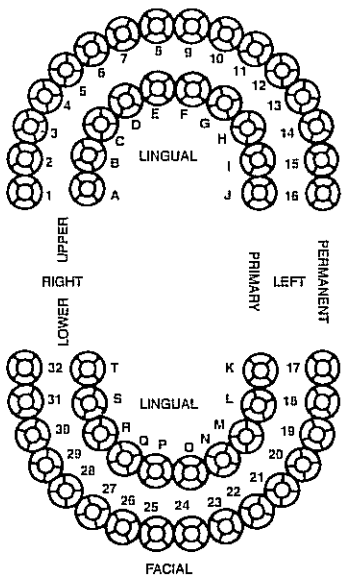
IS TREATMENT FOR ORTHODONTICS? NO YES

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 |
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New York Insurance regulations require the following statement be placed on claim form: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

TOTAL FEE CHARGED

PATIENT PAYS

DELTA PAYS

AMOUNT APPLIED TO DEDUCTIBLE

* **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 _____

FORM DD/NY-0016-00-04