DELTA DENTAL

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – **OR** – ☐ Request for Predetermination/Preauthorization

PRIMARY PAYER INFORMATION

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

PRIMARY SUBSCRIBER INFORMATION

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

5. Date of Birth (MM/DD/CCYY)	6. Gender ☐ M ☐ F	7. Subscriber Identifier (SSN or ID#)
8. Plan/Group Number	9. Employer Name	

PATIENT INFORMATION

10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	11. Student Status ☐ FTS ☐ PTS

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

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Patient ID/Account # (Assigned by Dentist)

CARRIER NAME AND ADDRESS:

2. Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532
(Please do not use for DeltaCare dental HMO)

OTHER COVERAGE

16. Other Dental or Medical Coverage? ☐ No (Skip 17-23) ☐ Yes (Complete 16-23)

17. Subscriber Name (Last, First, Middle Initial, Suffix)

18. Date of Birth (MM/DD/CCYY)	19. Gender ☐ M ☐ F	20. Subscriber Identifier (SSN or ID#)
21. Plan/Group Number	22. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

23. Other Carrier Name, Address, City, State, Zip Code

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								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

36. 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 activities in connection with this claim.

X_____
Patient/Guardian signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

37. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

38. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

39. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

40. Date Appliance Placed (MM/DD/CCYY)

41. Months of Treatment Remaining

42. Replacement of Prostheses? ☐ No ☐ Yes (Complete 44)

43. Date Prior Placement (MM/DD/CCYY)

44. Treatment Resulting from (Check applicable box) ☐ 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. Corporate Entity NPI (Type 2)	49. License Number	50. SSN or TIN

51. Phone Number ( ) –

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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

53. Individual NPI (Type 1)	54. License Number

55. Address, City, State, Zip Code

56. Phone Number ( ) –	57. Treating Provider Specialty