DELTA DENTAL

Delta Dental of Pennsylvania
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Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783
TTY/TDD 888-373-3582
www.MidAtlanticDeltaDental.com

ATTENDING DENTIST'S STATEMENT

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 | IMPORTANT 4 PATIENT BIRTHDATE MO DAY YR | 5 IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL CITY

6 EMPLOYEE/SUBSCRIBER NAME: LAST FIRST MIDDLE INITIAL | IMPORTANT 7 SUBSCRIBER I.D. NUMBER

8 EMPLOYEE HOME ADDRESS | CITY, STATE ZIP | ZIP CODE

9 EMPLOYER (COMPANY) NAME AND ADDRESS

OR 1 ____
OR 2 ____
OR 3 ____
OR 4 ____
OR 5 ____
OR 6 ____

10 GROUP NUMBER | IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15

11 DELTA - COVERED EMPLOYEE BIRTHDATE MO DAY YR

12 SPOUSE NAME

13 SPOUSE BIRTHDATE MO DAY YR

14 NAME AND ADDRESS OF CARRIER

15 SPOUSE I.D. NUMBER

DENTIST NAME
MAILING ADDRESS
CITY, STATE ZIP

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, ENTER REASON FOR REPLACEMENT

DENTIST I.D. NUMBER | DENTIST LICENSE | DENTIST PHONE NO

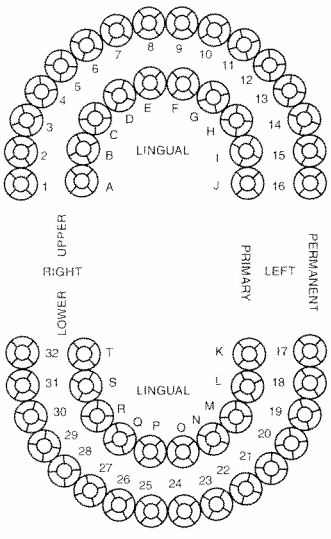
DATE OF PRIOR PLACEMENT

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT: OFFICE OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY?

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 Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO DAY YR		ADA PROCEDURE NUMBER	FEE

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.

* PREDETERMINATION OF COSTS
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS

DENTIST SIGNATURE DATE

** TREATMENT COMPLETED – PAYMENT REQUESTED
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, 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 _____

TOTAL FEE CHARGED	
PATIENT PAYS	
DELTA PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

FORM DD/PA-0016-04-10