DELTA DENTAL

4818 Starkey Road
Roanoke, VA 24018

❒ **Claim For Payment**

❒ **Claim For Predetermination**

(540) 989-8000 or (1-800) 237-6060

EMPLOYEE/SUBSCRIBER MUST COMPLETE SECTIONS 1-17

1. PATIENT NAME	2. RELATIONSHIP TO SUBSCRIBER: SELF / SPOUSE / CHILD / OTHER	3. SEX: M / F	4. PATIENT BIRTHDATE: MO. / DAY / YEAR	5. IF PATIENT IS CHILD AGE 19 OR OVER, FULL TIME STUDENT: NO ☐ YES ☐	NAME OF SCHOOL

6. SUBSCRIBER	FIRST	MIDDLE	LAST	7. SUBSCRIBER ID	8. NAME OF EMPLOYER
10. SUBSCRIBER MAILING ADDRESS				9. GROUP NUMBER	
11. CITY STATE, ZIP					

12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO ☐ YES ☐ IF YES: Þ

13. EMPLOYEE NAME AND BIRTHDATE

14. SOCIAL SEC. NO.

15. EMPLOYER NAME

16. NAME AND ADDRESS OF CARRIER

17. GROUP NO.

NAME OF DENTIST OR DENTAL ENTITY		TAX ID OR SOC. SEC. NO. / Type 2 NPI	IS TREATMENT RESULT OF ACCIDENT? NO ❒ YES ❒ IF YES, DATE IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY NO ❒ YES ❒
MAILING ADDRESS		LICENSE NO. / Type 1 NPI	RADIOGRAPHS OR MODELS ENCLOSED? NO ❒ YES ❒ HOW MANY? IF PROSTHESIS: IS THIS INITIAL PLACEMENT? NO ❒ YES ❒ IF NO, ENTER REASON FOR REPLACEMENT AND DATE OF PLACEMENT IN REMARKS BELOW
CITY STATE, ZIP		TELEPHONE NO.	IS TREATMENT FOR ORTHODONTICS? NO ❒ YES ❒ IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCE PLACED: MOS TREATMENT REMAINING:

DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE	DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE
										TOTAL	**FEE**

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO.

I CERTIFY THE TRUTH OF PERSONAL INFORMATION CONTAINED ABOVE.

I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.

PATIENT (PARENT OR EMPLOYEE) SIGNATURE DATE

(TREATMENT COMPLETED-PAYMENT REQUESTED)

THE TREATMENT LISTED WAS COMPLETED AND WAS NECESSARY IN MY PROFESSIONAL JUDGEMENT. I REQUEST PAYMENT IN ACCORDANCE WITH DDVA PARTICIPATING DENTIST RULES.

DENTIST SIGNATURE **DATE**

(PREDETERMINATION OF COST)

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST AUTHORIZATION IN ACCORDANCE WITH DDVA PARTICIPATING DENTIST RULES.

DENTIST SIGNATURE **DATE**