DELTA DENTAL

❐ **Claim For Payment**

❐ **Claim For Predetermination**

Delta Dental of Virginia
4818 Starkey Road
Roanoke, VA 24018
(540)989-8000 or (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 CHILD AGE 19 OR OVER: FULL TIME STUDENT: NO ☐ YES ☐ NAME OF SCHOOL
6. SUBSCRIBER FNAME MI LNAME	7. SUBSCRIBER IDENTIFICATION NO			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: →	13. EMPLOYEE NAME AND BIRTHDATE 16. NAME AND ADDRESS OF CARRIER	14. SUBSCRIBER ID NO.		15. EMPLOYER NAME 17. GROUP NO.

NAME OF DENTISTOR DENTAL ENTITY	TAX ID OR SOC. SEC. NO.	IS TREATMENT RESULT OF ACCIDENT? NO ❐ YES ❐ IF YES, DATE IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY NO ❐ YES ❐
MAILING ADDRESS	LICENSE NO.	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 CODE	TELEPHONE NO.	IS TREATMENT FOR ORTHODONTICS? NO ❐ YES ❐ IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCE PLACED: MONTHS TREATMENT REMAINING:

DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE
Periodic Exam				**D0120**	
Limited Oral Eval				**D0140**	
Comp Series-BW				**D0210**	
Periapical 1st film				**D0220**	
Periapical EA Add ( )				**D0230**	
1-BW-X-Ray				**D0270**	
2-BW-X-Ray				**D0272**	
4-BW-X-Ray				**D0274**	
Panoramic Film				**D0330**	
Prophy – Adult				**D1110**	
Prophy – Child				**D1120**	
Fluoride – Child				**D1203**	
Sealant				**D1351**	
Amalgam 1SF				**D2140**	
Amalgam 1SF				**D2140**	
Amalgam 1SF				**D2140**	
Amalgam 2SF				**D2150**	
Amalgam 2SF				**D2150**	
Amalgam 3SF				**D2160**	
Amalgam 3SF				**D2160**	
Amalgam 4SF				**D2161**	
Comp 1SF (Ant)				**D2330**	
Comp 1SF (Ant)				**D2330**	
Comp 1SF (Ant)				**D2330**	
Comp 2SF (Ant)				**D2331**	
Comp 3SF (Ant)				**D2332**	
Comp 1SF (Post)				**D2391**	
Comp 1SF (Post)				**D2391**	
Comp 1SF (Post)				**D2391**	
Comp 2SF (Post)				**D2392**	
Comp 3SF (Post)				**D2393**	
Pulpotomy				**D3220**	
RCT-Ant				**D3310**	
RCT-Bicsp				**D3320**	
RCT-Molar				**D3330**	
Perio Scal/Rt Plan				**D4341**	
Perio Maint				**D4910**	

DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE
Extraction				**D7140**	
Extraction				**D7140**	
Extraction				**D7140**	

TOTAL FEE CHARGED

ANY SERVICE EXCEEDING $250.00 SHOULD BE PRE-DETERMINED
CLAIM MUST BE FILED WITHIN ONE YEAR OF DATE OF SERVICE

REMARKS FOR UNUSUAL SERVICES

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 x 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 x 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 x DATE