DELTA DENTAL®

## HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services **– OR –** ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

## CARRIER NAME AND ADDRESS:

2. Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

## PRIMARY PAYER INFORMATION

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

## OTHER COVERAGE

16. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

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

## 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 | |

| 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

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## 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) |
|---|---|---|

## 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

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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 40-41) ☐ Yes (Complete 40-41) | 40. Date Appliance Placed (MM/DD/CCYY) |
| 41. Months of Treatment Remaining | 42. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 43) / 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. Provider ID | 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. Provider ID | 54. License Number |
|---|---|

55. Address, City, State, Zip Code

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