

1. PLEASE TYPE OR PRINT
2. DO NOT USE A HIGHLIGHTER
3. STAPLE X-RAYS TO TOP RIGHT CORNER
4. SEND PAGE 1 TO DELTA

DELTA DENTAL OF CALIFORNIA ENCOURAGES DENTAL OFFICES TO SUBMIT CLAIMS ELECTRONICALLY.



P.O. Box 997330
Sacramento, CA 95899-7330
Customer Service (888) 335-8227

DELTA USE ONLY

Delta Dental of California

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME			2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER			3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YEAR			5. IF FULL TIME STUDENT AND OVER AGE 18, INDICATE: SCHOOL CITY			
6. EMPLOYEE/ SUBSCRIBER NAME			7. EMPLOYEE SOCIAL SECURITY NUMBER			8. EMPLOYEE BIRTHDATE MO. DAY YEAR			9. EMPLOYER (COMPANY) NAME AND ADDRESS/ UNION LOCAL			10. GROUP NUMBER		
EMPLOYEE MAILING ADDRESS			APT. NO.			PHONE NO.								
CITY, STATE, ZIP			ZIP CODE											
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15.			12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.			12b. GROUP NUMBER			13. NAME AND ADDRESS OF EMPLOYER, ITEM 11					
YES NO														
14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)			14b. EMPLOYEE SOCIAL SECURITY NUMBER			14c. EMPLOYEE BIRTHDATE MO. DAY YEAR			15. RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER					
16. DENTIST NAME			LICENSE NUMBER			24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			NO YES			IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.		
17. MAILING ADDRESS			PHONE NO.			25. IS TREATMENT RESULT OF AUTO ACCIDENT?								
CITY, STATE, ZIP			ZIP CODE			26. OTHER ACCIDENT?								
						27. ARE ANY SERVICES COVERED BY A NON- DENTAL PLAN?								
18. DENTIST SOC. SEC. NO. OR T.I.N.			19. DENTIST LICENSE NO.			20. DENTIST PHONE NO.			28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.			29. DATE OF PRIOR PLACEMENT		
21. FIRST VISIT DATE CURRENT SERIES			22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER			23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES			HOW MANY?			30. IS TREATMENT FOR ORTHODONTICS? NO YES		
												IF SERVICES ALREADY COMMENCED ENTER		

IDENTIFY MISSING TEETH WITH "X"		31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32, USE CHARTING SYSTEM SHOWN.									
		TOOTH NO. OR LETTER	SUR- FACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y	PROCEDURE NUMBER	FEE				
				1							
				2							
				3							
				4							
				5							
				6							
				7							
				8							
				9							
				10							
				11							
				12							
				13							
				14							
				15							
32. REMARKS FOR UNUSUAL SERVICES OR											
AMOUNT PAID BY OTHER COVERAGE											

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE. SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____ DATE _____ <i>You may receive a copy of this authorization on request.</i>		TOTAL FEE CHARGED					
		PATIENT PAYS					
		PLAN PAYS					
PREDETERMINATION OF COST THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST A PREDETERMINATION OF COST. DENTIST SIGNATURE _____ DATE _____		TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM. DENTIST SIGNATURE _____ DATE _____		AMOUNT APPLIED TO DEDUCTIBLE			

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

1. SUBMIT PAGE 1 TO DELTA.
2. RETAIN PAGE 2 FOR YOUR FILES.