

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION																													
1. <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES <input type="checkbox"/> PREDETERMINATION REQUEST																													
MAIL CLAIMS TO	DELTA DENTAL P.O. BOX 9085 FARMINGTON HILLS, MI 48333-9085																												
OTHER COVERAGE																													
2. OTHER DENTAL OR MEDICAL COVERAGE? <input type="checkbox"/> NO IF NO, SKIP TO #11 <input type="checkbox"/> YES	3. AMOUNT OF PRIMARY PAYMENT \$																												
4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																													
5. DATE OF BIRTH	6. GENDER <input type="checkbox"/> M <input type="checkbox"/> F																												
8. PLAN/GROUP NUMBER	9. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER																												
10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME																													
SUBSCRIBER INFORMATION																													
11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																													
12. DATE OF BIRTH	13. GENDER <input type="checkbox"/> M <input type="checkbox"/> F																												
15. PLAN/GROUP NUMBER	16. EMPLOYER NAME																												
1009																													
PATIENT INFORMATION																													
17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)																													
18. RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	19. DATE OF BIRTH																												
20. GENDER <input type="checkbox"/> M <input type="checkbox"/> F																													
21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> TOTALLY & PERM DISABLED <input type="checkbox"/> IRS DEPENDENT <input type="checkbox"/> SPONSORED DEPENDENT																													
DENTAL SERVICES																													
22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION	28. FEE																							
MISSING TEETH		PERMANENT										PRIMARY										29. TOTAL FEE CHARGED							
30. PLACE X ON MISSING TOOTH NUMBERS		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		
REMARKS																													
31.																													
AUTHORIZATIONS															ADDITIONAL CLAIM INFORMATION														
32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.															34. PLACE OF TREATMENT <input type="checkbox"/> DENTAL OFFICE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ECF <input type="checkbox"/> OTHER														
PATIENT/GUARDIAN SIGNATURE _____ DATE _____															35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____														
33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.															36. IS TREATMENT RELATED TO ORTHODONTICS? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____														
SUBSCRIBER SIGNATURE _____ DATE _____															37. TREATMENT RESULTING FROM: <input type="checkbox"/> OCCUPATIONAL ILLNESS/INJURY <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER ACCIDENT														
															38. REPLACEMENT OF PROSTHESIS? <input type="checkbox"/> YES DATE PRIOR PLACEMENT _____ <input type="checkbox"/> NO														
BILLING DENTIST/DENTAL ENTITY (#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)															TREATING DENTIST AND LOCATION														
39. NAME, ADDRESS, CITY, STATE, ZIP															44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO PREDETERMINE THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGEMENT.														
															X _____ SIGNED (TREATING DENTIST) _____ DATE _____														
40. NPI					41. LICENSE NUMBER					42. TIN					45. NPI					46. LICENSE NUMBER					47. TIN				
43. PHONE NUMBER () () ()															48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)														
49. PHONE NUMBER () () ()															50. ADDITIONAL DENTIST ID					51. SPECIALTY CODE									

For the fastest processing, submit claims electronically through our **Dental Office Toolkit!**
It's free, easy, and available to all dentists. Check our Web sites for more information.

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- Clearly type, hand write, or use a computer printer to enter information.
- Use all upper-case (capital) letters, if possible.
- Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.
- Keep information within the correct field.
- Make sure the typewriter or printer ribbon is dark and the print can be easily read.
- Cover mistakes with line tape and print or type over—do not use liquid correction fluid.
- Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter \$0 unless the primary carrier's determination of payment was \$0. DO NOT ATTACH the primary carrier's voucher.
- Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- Hand or machine print
- When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).
- Use current ADA CDT procedure codes.
- Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.

FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.
- Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.
- Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS TO:	MAIL INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085	Delta Dental Attn: Customer Service P.O. Box 30416 Lansing, MI 48909-7916	(877) 334-5008

Delta Dental of Michigan
www.deltadentalmi.com

Delta Dental of Ohio
www.deltadentaloh.com

Delta Dental of Indiana
www.deltadentalin.com