ATTENDING DENTIST'S STATEMENT

MAIL ORIGINAL TO: ➤

DELTA DENTAL

P.O. Box 9085
Farmington Hills, Michigan 48333-9085

PLEASE TYPE ALL REQUIRED INFORMATION
SEE REVERSE FOR INSTRUCTIONS

MARK (X) APPROPRIATE BOX

DENTIST'S STATEMENT OF ACTUAL SERVICES		DENTIST'S PRE-DETERMINATION REQUEST.	

PATIENT & SUBSCRIBER INFORMATION

1. PATIENT NAME FIRST LAST MIDDLE INITIAL

2. PATIENT RELATIONSHIP TO SUBSCRIBER SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

3. PATIENT SEX MALE ☐ FEMALE ☐

4. PATIENT BIRTHDATE MM DD CC/YY

5. SUBSCRIBER NUMBER

6. SUBSCRIBER BIRTHDATE MM DD CC/YY

7. GROUP NUMBER

8. IF PATIENT IS A DEPENDENT OVER 19, PLEASE INDICATE STATUS
☐ FULL TIME STUDENT ☐ TOTALLY & PERM DISABLED ☐ IRS DEPENDENT ☐ SPONSORED DEPENDENT

9. SUBSCRIBER NAME FIRST LAST MIDDLE INITIAL

8a. ☐ ONLY FOR STATES ALLOWING ASSIGNMENT (SEE REVERSE): I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE GROUP DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE BELOW NAMED DENTIST, AND SIGN ON LINE 11

10. SUBSCRIBER MAILING ADDRESS

11. SUBSCRIBER SIGNATURE DATE

12. CITY STATE ZIP CODE

13. EMPLOYER/COMPANY NAME

IF PATIENT IS COVERED BY ANOTHER PLAN, COMPLETE ITEMS 14-24

14. SUBSCRIBER NAME FIRST LAST MIDDLE INITIAL

15. OTHER SUBSCRIBER NUMBER

16. BIRTHDATE MM DD CC/YY

17. GROUP NUMBER

18. AMOUNT OF PRIMARY PAYMENT $

19. MAILING ADDRESS

22. NAME OF OTHER CARRIER

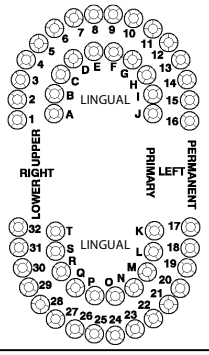
20. CITY STATE ZIP CODE

23. CARRIER ADDRESS

21. NAME OF EMPLOYER

24. CITY STATE ZIP CODE

IDENTIFY MISSING TEETH WITH "X"



PROVIDER INFORMATION

25. PROVIDER BUSINESS NAME

26. PROVIDER TAX IDENTIFICATION NUMBER

27. SERVICE OFFICE ADDRESS (NUMBER/STREET)

28. DDS LIC. NO.

29. STATE

30. SPEC. CD.

31. CITY STATE ZIP CODE

32. DENTIST PHONE NO. ( )

33. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS INJURY? No ☐ Yes ☐

34. RADIOGRAPHS OR MODELS ENCLOSED? No ☐ Yes ☐ HOW MANY?

35a. IS TREATMENT RELATED TO ORTHODONTICS? No ☐ Yes ☐

35b. IF SERVICE ALREADY COMMENCED, DATE APPLIANCES PLACED MM DD CC/YY

35c. OF ACTIVE MONTHS OF TREATMENT NUMBER

CAREFULLY FORM CHARACTERS AS SHOWN. A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0 1 2 3 4 5 6 7 8 9

TOOTH NUMBER OR LETTER	SURFACE	DATE SERVICE PERFORMED MM DD YY	PROCEDURE NUMBER	FEE $ DOLLARS	CENTS

DO NOT TYPE IN SHADED AREA

REMARKS

I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO PREDETERMINE THE PROCEDURES WHICH ARE NOT DATED AND THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGEMENT.

SIGNED (DENTIST) DATE

$ TOTAL FEE CHARGED

241-02 (7-00)

Delta Dental Plan of Michigan
Subscribers
1-800-482-8915
Dental Offices
1-800-462-7283
www.deltadentalmi.com

Delta Dental Plan of Ohio
Dental Offices / Subscribers
1-800-282-0749
www.deltadentaloh.com

Delta Dental Plan of Indiana
Dental Offices / Subscribers
1-800-292-0626
www.deltadentalin.com

DeltaUSA
Dental Offices / Subscribers
1-800-524-0149

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM FORM

Please use this claim form for subscribers of Delta Dental Plan of Michigan, Delta Dental Plan of Ohio and Delta Dental Plan of Indiana, as well as DeltaUSA subscribers of these plans.

FOR THIS CLAIM TO BE OPTICALLY SCANNED:

- All of the information above the service area of the claim form must be clearly typed, handwritten, or computer printed. If computer printed, be sure that the type alignment is correct.
- All upper case letters are preferred.
- Write characters as shown on the chart on the claim form, placing characters between the separator marks.
- Use a black or blue ballpoint pen or felt tip pen. DO NOT USE RED AND GREEN INK.
- Keep all information within the numbered boxes and within the correct fields.
- Make sure typewriter and printer ribbons are dark and the print can be easily read.
- Mistakes should be covered with line tape and printed or typed over. Do not use white-out or highlighter.
- If you staple anything to the form, do so only at the lower front edge of the form.

PATIENT AND SUBSCRIBER INFORMATION:

- For patient and subscriber information (boxes 1 and 9), enter the first name, last name and middle initial in that order. Do not use titles such as 'Mr.' or 'Ms.'
- When services are rendered by nonparticipating dentists, payment is issued to the subscriber. If benefits are to be assigned, complete box 8a. Box 8a is applicable only in cases where the patient:
  1. Is treated by a provider outside of the state of the group's contract, or
  2. Is enrolled in a Delta Dental Plan of Indiana program, the provider is nonparticipating and he / she practices in the state of Indiana, or
  3. Is enrolled in DeltaUSA and the provider is nonparticipating in one of the states listed below. (This list is subject to change.)

Alaska	Florida	Idaho	Louisiana	Montana	Oregon	Utah
Alabama	Georgia	Indiana	Mississippi	Nevada	Texas	Washington

- The subscriber's signature, box 11, is needed only when the subscriber is assigning benefits (if allowed per above). Make sure the signature fits entirely within the box.
- In cases where there is another carrier involved, complete the coordination of benefits section, boxes 14-24. If not, leave these boxes empty. Don't use zeroes, lines or N / A for not applicable. Box 18, amount of primary payment, should be filled in only when you know how much the primary carrier paid. Do not put $0 unless the primary carrier's actual payment determination was $0. Do NOT attach the primary carrier voucher.

PROVIDER INFORMATION:

- Enter the provider name or business name in Box 25. It must exactly match the business name that is on file with Delta Dental.
- Include the provider Tax Identification Number (box 26) and the license number of the treating dentist (box 28) on all claims.
- Complete boxes 35b and 35c, orthodontics, only if treatment is related to orthodontics. Otherwise, leave them blank. Do not enter zeroes, lines or N / A for not applicable.

SERVICE SECTION (bottom portion):

- This section can be hand printed or machine printed.
- Machine printed information should be double spaced vertically using regular horizontal spacing as long as it is within the boxes; it is not necessary to print one character per separator.
- List fees as dollars and cents with or without a decimal point. Because the scanner reads the last two digits as cents, if you list 25 for $25, the scanner will read it as 25 cents. Enter 2500 for $25.
- The remarks section should be used only for information pertaining to: the treatment rendered; determining primary / secondary coverage, such as for custodial information pertaining to a dependent; the diagnosis and treatment plan for orthodontics. Be sure to put all remarks in the remarks box or the information will be lost.
- The dentist's signature can be written, machine printed or stamped, but be sure that it is in dark ink and that it does not extend into the remarks section.

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.