DELTA DENTAL

Delta Dental of Pennsylvania

One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

ATTENDING DENTIST'S STATEMENT

SIGN BELOW FOR PREDETERMINATION * OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME

2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER

3. SEX: M | F

IMPORTANT
4. PATIENT BIRTHDATE: MO. | DAY | YEAR

5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL | CITY

6. EMPLOYEE/ SUBSCRIBER NAME: LAST | FIRST | MIDDLE INT.

IMPORTANT
7. EMPLOYEE SOCIAL SECURITY NUMBER

OR 1____
OR 2____
OR 3____
OR 4____
OR 5____
OR 6____

8. EMPLOYEE HOME ADDRESS

CITY, STATE ZIP

ZIP CODE

9. EMPLOYER (COMPANY) NAME AND ADDRESS

Messiah College

10. GROUP NUMBER

4161

IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15

11. DELTA - COVERED EMPLOYEE BIRTHDATE: MO. | DAY | YEAR

12. SPOUSE NAME

13. SPOUSE BIRTHDATE: MO. | DAY | YEAR

14. NAME AND ADDRESS OF CARRIER

15. SPOUSE SOCIAL SECURITY NUMBER

DENTIST NAME

MAILING ADDRESS

CITY, STATE ZIP

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	NO	YES	IF NO, ENTER REASON FOR REPLACEMENT

DATE OF PRIOR PLACEMENT

IS TREATMENT FOR ORTHODONTICS? NO | YES

IF SERVICES ALREADY COMMENCED, ENTER:

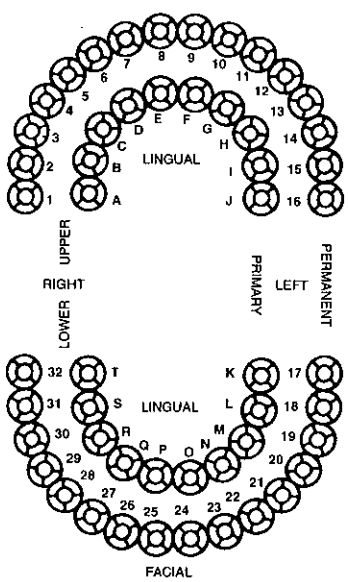
DATE APPLIANCES PLACED

MONTHS TREATMENT REMAINING

DENTIST SOC. SEC. NO. OR FED. IDENT. NO. | DENTIST LICENSE | DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT: OFFICE | OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY?

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YR.		ADA PROCEDURE NUMBER	FEE

* PREDETERMINATION OF COSTS
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS

DENTIST SIGNATURE | DATE

** TREATMENT COMPLETED – PAYMENT REQUESTED
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.

DENTIST SIGNATURE | DATE

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.

PATIENT SIGNATURE _____

DATE _____

TOTAL FEE CHARGED	
PATIENT PAYS	
DELTA PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

FORM DD/PA-0016-02-05