# DELTA DENTAL®

# DENTAL CLAIM FORM

Delta Dental Plan of Iowa
P.O. Box 919 • Ankeny, Iowa 50021-0919

| ATTENDING DENTIST'S STATEMENT | PATIENT ACCOUNT NUMBER |
|---|---|
| ☐ PRETREATMENT REQUEST<br>☐ STATEMENT OF ACTUAL SERVICES | |

## PATIENT SECTION

| 1. PATIENT NAME (LAST) (FIRST) (INITIAL) | 2.RELATIONSHIP TO SUBSCRIBER<br>☐ SELF ☐ SPOUSE ☐ DEPENDENT |
|---|---|
| 3.SEX ☐ M ☐ F<br>4.PATIENT BIRTH DATE MONTH DAY YEAR<br>5.IF FULL TIME STUDENT CITY STATE | 7.SUBSCRIBER IDENTIFICATION NUMBER |
| 6.SUBSCRIBER NAME (LAST) (FIRST) (INITIAL) | SUBSCRIBER HOME PHONE NUMBER ( )<br>SUBSCRIBER WORK PHONE NUMBER ( ) |
| 8.SUBSCRIBER ADDRESS (STREET OR RFD NUMBER, CITY, STATE, ZIP CODE) | 9.EMPLOYER NAME AND ADDRESS (STREET, CITY, STATE, ZIP) |
| 10. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO<br>DENTAL PLAN NAME UNION LOCAL GROUP NUMBER | |
| NAME AND ADDRESS OF OTHER INSURANCE COMPANY | |

I hereby accept the treatment below and authorize release of any information relating to this claim.

PATIENT/PARENT OR EMPLOYEE-MEMBER SIGNATURE **X** _____ DATE _____

## DENTIST SECTION

**PLEASE PROVIDE TOOTH NUMBERS WHEN REQUIRED**

| 11. DENTIST NAME | 12.ADDRESS (STREET, CITY, STATE, ZIP) | 16. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY? | YES | NO | IF YES, ENTER BRIEF DESCRIPTION AND DATES |
|---|---|---|---|---|---|
| | | 17. IS TREATMENT A RESULT OF AUTO ACCIDENT? | | | |
| | | OTHER ACCIDENT? | | | |

| 13. TAX I.D. NUMBER | 14.DENTIST LICENSE NUMBER | 15.DENTIST PHONE NUMBER | 18. IS TREATMENT FOR ORTHODONTICS? | | IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED | MONTHS TREATMENT REMAINING |
|---|---|---|---|---|---|---|
| | | | | | | |

## DIAGNOSTIC AND TREATMENT RECORD

LIST IN TOOTH ORDER (1 - 32 OR A - T)

ARE X-RAYS OR OTHER REVIEW DOCUMENTS ATTACHED? ☐ YES ☐ NO 19.PLACE OF TREATMENT ☐ OFFICE ☐ HOSPITAL ☐ OTHER

| TOOTH # OR LETTER | QUAD | SURFACES | DESCRIPTION OF SERVICE | COMPLETION DATE MONTH / DATE / YEAR | PROCEDURE CODE | CHARGE |
|---|---|---|---|---|---|---|
| | | | 1.) | | | |
| | | | 2.) | | | |
| | | | 3.) | | | |
| | | | 4.) | | | |
| | | | 5.) | | | |
| | | | 6.) | | | |
| | | | 7.) | | | |
| | | | 8.) | | | |
| | | | 9.) | | | |
| | | | 10.) | | | |

I hereby certify that the services listed above have been completed and to the best of my knowledge are within the provisions of the plan, payment is therefore due.

TREATING DENTIST SIGNATURE **X** _____ DATE _____

**OUT OF STATE DENTISTS ONLY:**

**ARE YOU A DELTA DENTALDENTIST?**

☐ YES ☐ NO

IF YES, PLEASE PROVIDE TAX I.D.#

_____

| | | |
|---|---|---|
| **TOTAL** | | |
| **LESS THIRD PARTY PAYMENTS** | | |
| **NET CHARGE** | | |