

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

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



P.O. Box 997330
Sacramento, California 95899-7330

DELTA USE ONLY

Customer Service: 888-335-8227
www.deltadentalins.com

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

1. PATIENT NAME FIRST MIDDLE LAST			2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER			3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YEAR			5. IF FULL TIME STUDENT OVER 18, INDICATE: SCHOOL CITY				
6. EMPLOYEE/SUBSCRIBER NAME				7. EMPLOYEE SOCIAL SECURITY NUMBER				8. EMPLOYEE BIRTHDATE MO. DAY YEAR			9. EMPLOYEE (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. YES NO				12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.				12b. GROUP NUMBER		13. NAME AND ADDRESS OF EMPLOYER, ITEM 11					
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 CHILD 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?		NO		YES					
CITY, STATE, ZIP		ZIP CODE				26. OTHER ACCIDENT?		NO		YES					
18. DENTIST SOC. SEC. NO. OR T.J.N.			19. DENTIST LICENSE NO.			20. DENTIST PHONE NO.			27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?			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	DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING

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 THE DATE. SIGNATURE OF PARENT (OR PARENT OR GUARDIAN) _____ DATE _____ <i>You may receive a copy of this authorization on request.</i>		TOTAL FEE CHARGED	
		PATIENT PAYS	
PREDETERMINATION OF COST THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF COST. DENTIST SIGNATURE _____ DATE _____		DELTA PAYS	
		AMOUNT APPLIED TO DEDUCTIBLE	
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 TO STATE ON THIS FORM. DENTIST SIGNATURE _____ DATE _____			

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

ATTENDING DENTIST'S STATEMENT
Delta 105 (rev. 11/07) #44555

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