



Delta Dental of New York

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Mechanicsburg, PA 17055-6999
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ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION
OR PAYMENT \*\*

STAPLE X-RAYS TO FORM

1. PATIENT NAME, 2. RELATIONSHIP TO EMPLOYEE, 3. SEX, 4. PATIENT BIRTHDATE, 5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL, CITY, 6. EMPLOYEE/SUBSCRIBER NAME, 7. EMPLOYEE SOCIAL SECURITY NUMBER, 8. EMPLOYEE HOME ADDRESS, 9. EMPLOYER (COMPANY) NAME AND ADDRESS, 10. GROUP NUMBER, 11. DELTA COVERED EMPLOYEE BIRTHDATE, 12. SPOUSE NAME, 13. SPOUSE BIRTHDATE, 14. NAME AND ADDRESS OF CARRIER, 15. SPOUSE SOCIAL SECURITY NUMBER

DENTIST NAME, MAILING ADDRESS, CITY, STATE ZIP, 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?, HOW MANY?, IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?, IS TREATMENT RESULT OF AUTO ACCIDENT?, OTHER ACCIDENT?, IF PROSTHESIS, IS THIS INITIAL PLACEMENT?, DATE OF PRIOR PLACEMENT, IS TREATMENT FOR ORTHODONTICS?, IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED, MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X" FACIAL, 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, 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/NY-0016-99-03