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

1. PLEASE TYPE OR PRINT, 2. DO NOT USE A HIGHLIGHTER, 3. STAPLE X-RAYS TO TOP RIGHT CORNER

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

1. PATIENT NAME		2. RELATIONSHIP TO SUBSCRIBER SELF SPOUSE CHILD OTHER		3. SEX M F		4. PATIENT BIRTHDATE MONTH DAY YEAR			5. IF FULL TIME STUDENT OVER 18, INDICATE: SCHOOL CITY				
6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST			7. SUBSCRIBER ID NUMBER			8. SUBSCRIBER BIRTHDATE MONTH DAY YEAR			9. EMPLOYER (COMPANY) NAME AND ADDRESS/ UNION LOCAL		10. GROUP NUMBER		
SUBSCRIBER MAILING ADDRESS				APT. NO.		PHONE NO.							
CITY				STATE		ZIP CODE							
11. DOES PATIENT HAVE COVERAGE THROUGH ANOTHER COMPANY? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES <input type="checkbox"/> NO <input type="checkbox"/>			12A. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.			12B. GROUP NUMBER		13. NAME AND ADDRESS OF EMPLOYER, ITEM 11					
14A. SUBSCRIBER NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)			14B. SUBSCRIBER ID NUMBER			14C. SUBSCRIBER BIRTHDATE MONTH 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			
17. MAILING ADDRESS		25. IS TREATMENT RESULT OF AN AUTO ACCIDENT?		NO		YES		IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.					
CITY, STATE, ZIP		26. OTHER ACCIDENT?		NO		YES							
18. DENTIST SOCIAL SECURITY NUMBER OR T.I.N.		19. DENTIST LICENSE NUMBER		20. DENTIST PHONE NUMBER		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO ENTER REASON FOR REPLACEMENT.		NO		YES			
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE HOSPITAL ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		HOW MANY		30. IS TREATMENT FOR ORTHODONTICS?		NO		YES	
										DATE APPLIANCES PLACED		MOS. TREATMENT REMAINING	

IDENTIFY MISSING TEETH WITH "X" FACIAL LINGUAL UPPER RIGHT LOWER LEFT PRIMARY PERMANENT	31. EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.										
	TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y			PROCEDURE NUMBER	FEE			
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My dentist may give Delta Dental 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 patient (or parent or guardian) _____ Date _____ <i>You may receive a copy of this authorization on request.</i>		TREATMENT COMPLETED – PAYMENT REQUESTED The treatment listed was completed. I will charge and intend to collect the entire portion of the fees stated above that Delta Dental determines to be the patient's responsibility, and I will not waive, reduce or rebate any of that portion unless I expressly state on this form. Dentist Signature _____ Date _____	TOTAL FEE CHARGED	
PRE-TREATMENT ESTIMATE The treatment listed is necessary in my professional judgement, and I request a pre-treatment estimate. Dentist Signature _____ Date _____			PATIENT PAYS	
		DELTA DENTAL PAYS		
		AMOUNT APPLIED TO DEDUCTIBLE		