DELTA DENTAL

Delta Dental of New York

PO Box 2105
Mechanicsburg, PA 17055-2105
717-766-8500 800-932-0783
TTY/TDD 888-373-3582

SUBSCRIBER INFORMATION

1. Policyholder / Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

2. Date of Birth (MMDDCCYY)	3. Gender ☐M ☐F	4. Policyholder / Subscriber ID (SSN or ID#)
5. Plan or Group Number	6. Employer Name	

PATIENT INFORMATION

7. Relationship to Policyholder/Subscriber in #1 Above
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

8. Patient Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

9. Date of Birth (MMDDCCYY)	10. Gender ☐M ☐F	11. Patient ID/Account # (Assigned by Dentist)

12. Remarks

TRANSACTION AND PREDETERMINATION INFORMATION

13. Type of Transaction (Mark all Applicable Boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Pre-treatment Estimate
☐ EPSDT/ Title XIX ☐ Encounter

14. Predetermination/ Pre-treatment Estimate Number

TREATMENT INFORMATION

15. Treatment Resulting From
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

16. Date of Accident (MMDDCCYY)	17. Auto Accident State

18. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other	19. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

20. Is Treatment for Orthodontics? ☐ No (Skip 21-22) ☐ Yes (Complete 21-22)	21. Date Appliance Placed (MMDDCCYY)

22. Months of Treatment Remaining	23. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)	24. Date of Prior Placement (MMDDCCYY)

OTHER INSURANCE COVERAGE

25. Other Coverage? ☐ None ☐ Dental (Complete 26-32) ☐ Medical (Complete 26-32)

26. Name of Other Coverage Policyholder / Subscriber (Last, First, Middle Initial, Suffix)

27. Date of Birth (MMDDCCYY)	28. Gender ☐M ☐F	29. Policyholder / Subscriber ID (SSN or ID#)
30. Plan or Group Number	31. Patient's Relationship to Person Named in #26 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

32. Other Insurance Company / Dental Benefit Plan Name, Address, City, State, ZIP Code

33. Diagnosis Codes	A.	B.	C.	D.

RECORD OF SERVICES PROVIDED

	34. Procedure Date (MMDDCCYY)	35. Area of Oral Cavity	36. Tooth Number(s) or Letter(s)	37. Tooth Surface	38. Quantity	39. Procedure Code	40. Diagnosis Pointer (A, B, etc.)	41. Description	42. Fee
1									
2									
3									
4									
5									
6									
7									
8									

MISSING TEETH INFORMATION

44. (Place an 'X' on each missing tooth)

Permanent																Primary										43. Total Fee
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	0.00
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

AUTHORIZATION - RELEASE OF INFORMATION

45. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

AUTHORIZATION - ASSIGNMENT OF BENEFITS

46. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY

47. Dentist or Entity Name, Address, City, State, ZIP Code

48. NPI	
49. License Number	50. SSN or TIN
51. Phone Number	52. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed

X _____
Signed (Treating Dentist) Date

54. Treatment Location Address, City, State, ZIP Code

55. NPI	
56. License Number	57. Provider Specialty Code
58. Phone Number	59. Additional Provider ID