Delta Dental of New York

One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION *
OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME

2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER

3. SEX: M | F

IMPORTANT
4. PATIENT BIRTHDATE: MO. | DAY | YEAR

5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE: SCHOOL | CITY

6. EMPLOYEE/ SUBSCRIBER NAME: LAST | FIRST | MIDDLE INT.

IMPORTANT
7. EMPLOYEE SOCIAL SECURITY NUMBER

OR 1 ________
OR 2 ________
OR 3 ________
OR 4 ________
OR 5 ________
OR 6 ________

8. EMPLOYEE HOME ADDRESS

CITY, STATE ZIP

ZIP CODE

9. EMPLOYER (COMPANY) NAME AND ADDRESS

10. GROUP NUMBER

IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15

11. DELTA – COVERED EMPLOYEE BIRTH DATE: MO. | DAY | YEAR

12. SPOUSE NAME

13. SPOUSE BIRTHDATE: MO. | DAY | YEAR

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? NO ☐ YES ☐	HOW MANY?

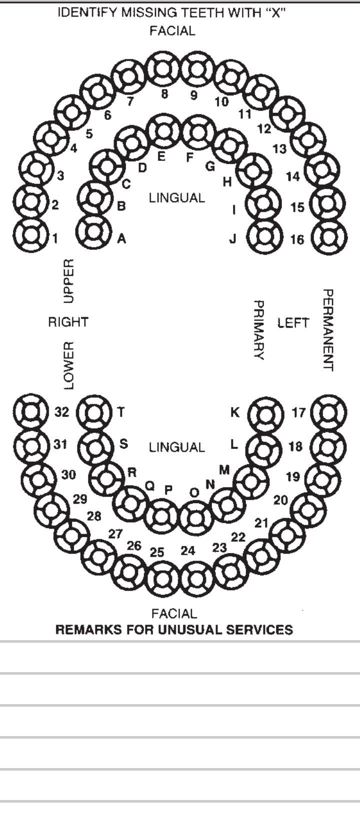
	NO	YES	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, ENTER REASON FOR REPLACEMENT

DATE OF PRIOR PLACEMENT

	NO	YES
IS TREATMENT FOR ORTHODONTICS?		

IF SERVICES ALREADY COMMENCED, ENTER:
DATE APPLIANCES PLACED
MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

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
		1						
		2						
		3						
		4						
		5						
		6						
		7						
		8						
		9						
		10						
		11						
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		18						
		19						
		20						

New York Insurance regulations require the following statement be placed on claim form: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

*** PREDETERMINATION OF COSTS**
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS.

DENTIST SIGNATURE DATE

**** TREATMENT COMPLETED – PAYMENT REQUESTED**
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.

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	