



Delta Dental of New York
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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 YR.		5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL		CITY
6. EMPLOYEE/SUBSCRIBER NAME LAST FIRST MIDDLE INITIAL		7. SUBSCRIBER I.D. NUMBER		IMPORTANT		OR 1		OR 2	
8. EMPLOYEE HOME ADDRESS		9. EMPLOYER (COMPANY) NAME AND ADDRESS		OR 3		OR 4		OR 5	
CITY, STATE ZIP		ZIP CODE		UUP Member Services Trust Fund - Part-Timers		OR 6			
10. GROUP NUMBER 00166		IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15		11. DELTA - COVERED EMPLOYEE BIRTHDATE MO. DAY YR.		12. SPOUSE NAME		13. SPOUSE BIRTHDATE MO. DAY YR.	
14. NAME AND ADDRESS OF CARRIER		15. SPOUSE I.D. NUMBER							

DENTIST NAME		IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
MAILING ADDRESS		IS TREATMENT RESULT OF AUTO ACCIDENT?					
CITY, STATE ZIP		OTHER ACCIDENT?					
DENTIST I.D. NUMBER		DENTIST LICENSE		DENTIST PHONE NO.		IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
FIRST VISIT DATE CURRENT SERIES		PLACE OF TREATMENT OFFICE OTHER		RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		HOW MANY? DATE OF PRIOR PLACEMENT	
						IS TREATMENT FOR ORTHODONTICS? NO <input type="checkbox"/> YES <input type="checkbox"/>	
						IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING	

IDENTIFY MISSING TEETH WITH "X" FACIAL LINGUAL UPPER RIGHT PERMANENT LOWER LEFT PRIMARY FACIAL 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 MOJ DLF	Description Of Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YR.	ADA PROCEDURE NUMBER	FEE	
			1				
			2				
			3				
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* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, 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	
** TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE. DENTIST SIGNATURE _____ DATE _____			PATIENT PAYS	
		DELTA PAYS		
		AMOUNT APPLIED TO DEDUCTIBLE		

FORM DD/NY-0016-04-10