

# DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION																												
1. <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES <input type="checkbox"/> PREDETERMINATION REQUEST																												
<b>MAIL CLAIMS TO</b> <b>DELTA DENTAL</b> <b>P.O. BOX 9085</b> <b>FARMINGTON HILLS, MI 48333-9085</b>						<b>SUBSCRIBER INFORMATION</b> 11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																						
OTHER COVERAGE																												
2. OTHER DENTAL OR MEDICAL COVERAGE? <input type="checkbox"/> NO IF NO, SKIP TO #11 <input type="checkbox"/> YES						3. AMOUNT OF PRIMARY PAYMENT \$																						
4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																												
12. DATE OF BIRTH				13. GENDER <input type="checkbox"/> M <input type="checkbox"/> F				14. SUBSCRIBER ID (SSN OR ID#)																				
15. PLAN/GROUP NUMBER <b>1009</b>						16. EMPLOYER NAME																						
PATIENT INFORMATION																												
5. DATE OF BIRTH						6. GENDER <input type="checkbox"/> M <input type="checkbox"/> F			7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)																			
17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)				18. RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER				19. DATE OF BIRTH		20. GENDER <input type="checkbox"/> M <input type="checkbox"/> F																		
8. PLAN/GROUP NUMBER						9. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER																						
10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME						21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> TOTALLY & PERM DISABLED <input type="checkbox"/> IRS DEPENDENT <input type="checkbox"/> SPONSORED DEPENDENT																						
DENTAL SERVICES																												
22. DATE OF SERVICE MM/DD/CCYY		23. AREA OF ORAL CAVITY		24. TOOTH NO. OR LETTER		25. TOOTH SURFACE		26. CURRENT CDT PROCEDURE CODE		27. DESCRIPTION		28. FEE																
1																												
2																												
3																												
4																												
5																												
6																												
7																												
8																												
9																												
10																												
MISSING TEETH		PERMANENT										PRIMARY										29. TOTAL FEE CHARGED						
30. PLACE X ON MISSING TOOTH NUMBERS		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
		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	
REMARKS																												
31.																												
AUTHORIZATIONS						ADDITIONAL CLAIM INFORMATION																						
32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.  PATIENT/GUARDIAN SIGNATURE _____ DATE _____						34. PLACE OF TREATMENT <input type="checkbox"/> DENTAL OFFICE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ECF <input type="checkbox"/> OTHER																						
33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.  SUBSCRIBER SIGNATURE _____ DATE _____						35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____																						
						36. IS TREATMENT RELATED TO ORTHODONTICS? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____																						
						37. TREATMENT RESULTING FROM: <input type="checkbox"/> OCCUPATIONAL ILLNESS/INJURY <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER ACCIDENT																						
						38. REPLACEMENT OF PROSTHESIS? <input type="checkbox"/> YES DATE PRIOR PLACEMENT _____ <input type="checkbox"/> NO																						
BILLING DENTIST/DENTAL ENTITY (#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)						TREATING DENTIST AND LOCATION																						
39. NAME, ADDRESS, CITY, STATE, ZIP						44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO PREDETERMINE THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGEMENT.  X _____ SIGNED (TREATING DENTIST) _____ DATE _____																						
40. NPI		41. LICENSE NUMBER		42. TIN		45. NPI		46. LICENSE NUMBER		47. TIN																		
43. PHONE NUMBER ( )						48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)																						
49. PHONE NUMBER ( )				50. ADDITIONAL DENTIST ID		51. SPECIALTY CODE																						

For the fastest processing, submit claims electronically through our **Dental Office Toolkit!**  
It's free, easy, and available to all dentists. Check our Web sites for more information.

## INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

### FOR CLAIMS TO BE OPTICALLY SCANNED:

- Clearly type, hand write, or use a computer printer to enter information.
- Use all upper-case (capital) letters, if possible.
- Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.
- Keep information within the correct field.
- Make sure the typewriter or printer ribbon is dark and the print can be easily read.
- Cover mistakes with line tape and print or type over—do not use liquid correction fluid.
- Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.

### FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter \$0 unless the primary carrier's determination of payment was \$0. DO NOT ATTACH the primary carrier's voucher.
- Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.

### FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- Hand or machine print
- When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).
- Use current ADA CDT procedure codes.
- Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.

### FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.
- Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.
- Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.

### NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS TO:	MAIL INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085	Delta Dental Attn: Customer Service P.O. Box 30416 Lansing, MI 48909-7916	(877) 334-5008

Delta Dental of Michigan  
[www.deltadentalmi.com](http://www.deltadentalmi.com)

Delta Dental of Ohio  
[www.deltadentaloh.com](http://www.deltadentaloh.com)

Delta Dental of Indiana  
[www.deltadentalin.com](http://www.deltadentalin.com)