DELTA DENTAL®

DENTAL CLAIM FORM

Delta Dental of Iowa
P.O. Box 9000
Johnston, Iowa 50131-9000
800-544-0718

ATTENDING DENTIST'S STATEMENT	PATIENT ACCOUNT NUMBER
☐ PRETREATMENT REQUEST ☐ STATEMENT OF ACTUAL SERVICES	

PATIENT SECTION

1. PATIENT NAME (LAST) (FIRST) (INITIAL)	2. RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT
3. SEX ☐ M ☐ F; 4. PATIENT BIRTH DATE MONTH DAY YEAR; 5. IF FULL TIME STUDENT CITY STATE	7. SUBSCRIBER IDENTIFICATION NUMBER
6. SUBSCRIBER NAME (LAST) (FIRST) (INITIAL)	SUBSCRIBER HOME PHONE NUMBER ( ) SUBSCRIBER WORK PHONE NUMBER ( )
8. SUBSCRIBER ADDRESS (STREET OR RFD NUMBER, CITY, STATE, ZIP CODE)	9. EMPLOYER NAME AND ADDRESS (STREET, CITY, STATE, ZIP)
10. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO; DENTAL PLAN NAME; UNION LOCAL; GROUP NUMBER	
NAME AND ADDRESS OF OTHER INSURANCE COMPANY	

I hereby accept the treatment below and authorize release of any information relating to this claim.

PATIENT/PARENT OR EMPLOYEE-MEMBER SIGNATURE **X** _____ DATE _____

DENTIST SECTION

PLEASE PROVIDE TOOTH NUMBERS WHEN REQUIRED

11. DENTIST NAME AND ADDRESS (STREET, CITY, STATE, ZIP)	12. NPI	13. DENTIST LICENSE NUMBER	14. TAX ID NUMBER	15. PHONE NUMBER

	YES	NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES
16. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY?			
17. IS TREATMENT A RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
18. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED; MONTHS TREATMENT REMAINING
19. IF PROTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT; 20. DATE OF PRIOR PLACEMENT

DIAGNOSTIC AND TREATMENT RECORD

LIST IN TOOTH ORDER (1 - 32 OR A - T)

ARE X-RAYS OR OTHER REVIEW DOCUMENTS ATTACHED? ☐ YES ☐ NO 21. PLACE OF TREATMENT ☐ OFFICE ☐ HOSPITAL ☐ OTHER

TOOTH # OR LETTER	QUAD	SURFACES	DESCRIPTION OF SERVICE	COMPLETION DATE MONTH / DATE / YEAR	PROCEDURE CODE	CHARGE
			1.)			
			2.)			
			3.)			
			4.)			
			5.)			
			6.)			
			7.)			
			8.)			
			9.)			

22. IDENTIFY ALL MISSING TEETH WITH AN X:

PERMANENT															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PRIMARY										
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

TOTAL		
LESS THIRD PARTY PAYMENTS		
NET CHARGE		

I hereby certify that the services listed above have been completed and to the best of my knowledge are within the provisions of the plan, payment is therefore due.

TREATING DENTIST SIGNATURE **X** _____ DATE _____

LICENSE NUMBER _____ NPI _____

PC-001 - 1/07