

Delta Dental of Pennsylvania

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

SIGN BELOW  
FOR PREDETERMINATION  
OR PAYMENT \*\*

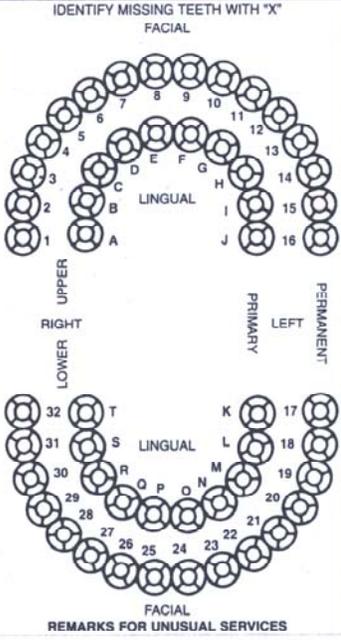
STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER			3. SEX M F	4. IMPORTANT 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.		7. EMPLOYEE SOCIAL SECURITY NUMBER			OR 1 _____	OR 2 _____	
8. EMPLOYEE HOME ADDRESS					9. EMPLOYER (COMPANY) NAME AND ADDRESS					OR 3 _____
CITY, STATE ZIP					CITY OF PHILADELPHIA					OR 4 _____
ZIP CODE										OR 5 _____
10. GROUP NUMBER	11. DELTA - COVERED EMPLOYEE BIRTHDATE MO. DAY YEAR		12. SPOUSE NAME		13. SPOUSE BIRTHDATE MO. DAY YEAR			15. SPOUSE SOCIAL SECURITY NUMBER		
0569	IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15									
14. NAME AND ADDRESS OF CARRIER										

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 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 <input type="checkbox"/> YES <input type="checkbox"/>		DATE OF PRIOR PLACEMENT
						IS TREATMENT FOR ORTHODONTICS? NO YES
						IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING

TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED			ADA PROCEDURE NUMBER	FEE
			MO.	DAY	YR.		
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* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS		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.	TOTAL FEE CHARGED	
DENTIST SIGNATURE	DATE		PATIENT PAYS	
** 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.		PATIENT SIGNATURE _____	DELTA PAYS	
DENTIST SIGNATURE	DATE	DATE _____	AMOUNT APPLIED TO DEDUCTIBLE	