DELTA HEALTH SYSTEMS

REFER TO YOUR I.D. CARD FOR PROPER MAILING ADDRESS

EMPLOYEE ID NUMBER

			-					

DENTAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION

1. PATIENT'S NAME	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE) ☐ CHECK HERE IF NEW ADDRESS

8. OTHER HEALTH INSURANCE COVERAGE
IS PATIENT COVERED BY ANY OTHER PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER:

IDENTIFICATION NUMBER _____ NAME OF EMPLOYER _____

TYPES OF COVERAGE BY CARRIER: ☐ MEDICAL ☐ DRUG ☐ DENTAL ☐ VISION

EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____

9. I AUTHORIZE THE UNDERSIGNED DENTIST TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.	10. I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO UNDERSIGNED DENTIST OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW.
SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____	SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____

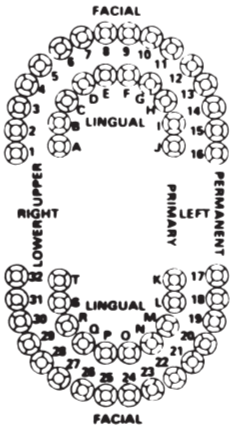
DENTIST'S INFORMATION

11. DENTIST OR GROUP NAME			19. IS TREATMENT RESULT OF OCCUPTIONAL ILLNESS OF INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
12. MAILING ADDRESS			20. IS TREATMENT RESULT OF AUTO ACCIDENT?			
CITY STATE ZIP			21. OTHER ACCIDENT?			
			22. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
13. SOC. SEC. OR T.I. NO.	14. TAXABLE ENTITY NAME (IF DIFFERENT THAN BOX 11)	15. DENTIST PHONE NO.	23. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 24. DATE OF PRIOR PLACEMENT
16. FIRST VISIT DATE CURRENT SERIES	17. PLACE OF TREATMENT OFFICE ; HOSP. ; ECF ; OTHER	18. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?	25. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

TO THE DENTIST: PREDETERMINATION OF BENEFITS REQUIRED FOR CLAIMS IN EXCESS OF $250.00

CHECK ONE: ☐ **DENTIST'S PRE-TREATMENT ESTIMATE** ☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

IDENTIFY MISSING TEETH WITH "X"



27. REMARKS FOR UNUSUAL SERVICES

26. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE
		X-RAY REQUIRED FOR MAJOR					
		WORK EXCEPT PERIODONTAL					
		AND ENDODONTIC					
		PERIODONTAL SERVICES					
		REQUIRE PERIO-CHART.					

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED (DENTIST) _____ DATE _____ TOTAL FEE CHARGED

57060 - K/P CORPORATION - MEDICAL SYSTEMS