



Delta Dental of Pennsylvania
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ATTENDING DENTIST'S STATEMENT

SIGN BELOW
 FOR PREDETERMINATION
 OR PAYMENT **
 STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE THIS 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								
	8. EMPLOYEE HOME ADDRESS		9. EMPLOYER (COMPANY) NAME AND ADDRESS								
	CITY, STATE ZIP		ZIP CODE								
	10. GROUP NUMBER		11. DELTA COVERED EMPLOYEE BIRTHDATE MO. DAY YR.		12. SPOUSE NAME		13. SPOUSE BIRTHDATE MO. DAY YR.		OR 1 _____ OR 2 _____ OR 3 _____ OR 4 _____ OR 5 _____ OR 6 _____		
	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?		NO	YES		
CITY, STATE ZIP		OTHER ACCIDENT?		NO	YES		
DENTIST I.D. NUMBER		DENTIST LICENSE		DENTIST PHONE NO.		IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO YES IF NO, ENTER REASON FOR REPLACEMENT	
FIRST VISIT DATE CURRENT SERIES		PLACE OF TREATMENT OFFICE OTHER		RADIOGRAPHS OR MODELS ENCLOSED? NO YES		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 Services 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 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 SIGNATURE _____ DATE _____		PATIENT PAYS	
				DELTA PAYS	
				AMOUNT APPLIED TO DEDUCTIBLE	

FORM DD/PA-0016-04-10