DELTA DENTAL®

DENTAL CLAIM FORM

Delta Dental Plan of Iowa
P.O. Box 919 • Ankeny, Iowa 50021-0919

ATTENDING DENTIST'S STATEMENT	PATIENT ACCOUNT NUMBER
☐ PRETREATMENT REQUEST ☐ SETTLEMENT 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 FULLTIME 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, ZIPCODE)	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 above treatment and authorize release of any information relating to this claim.

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

DENTIST SECTION

PLEASE PROVIDE TOOTH NUMBERS WHERE REQUIRED

11. DENTIST NAME 12. ADDRESS (STREET, CITY, STATE, ZIP)	16. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY?	YES	NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES
	17. IS TREATMENT A RESULT OF AUTO ACCIDENT?			
	OTHER ACCIDENT?			
13. TAX I.D. NUMBER 14. DENTIST LICENSE NUMBER 15. DENTIST PHONE NUMBER	18. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING

DIAGNOSTIC AND TREATMENT RECORD

LIST IN ORDER FROM TOOTH #1 THROUGH TOOTH #32

ARE X-RAYS OR OTHER BENEFIT REVIEW DOCUMENTS ATTACHED? ☐ YES ☐ NO

19. 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.)			
			10.)			

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

DENTIST SIGNATURE **X** _____ DATE _____

OUT OF STATE DENTISTS ONLY:

ARE YOU A DELTA MEMBER?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE TAX I.D. #

_____

TOTAL	
LESS THIRD PARTY PAYMENTS	
NET CHARGE	