DELTA DENTAL®

DeltaDentalTN.com

FOR ELIGIBILITY AND BENEFIT INFORMATION CALL

Toll Free: (800) 223-3104

Local: (615) 255-3175

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION

1. ☐ STATEMENT OF ACTUAL SERVICES ☐ PREDETERMINATION REQUEST

MAIL CLAIMS TO → **DELTA DENTAL**
240 VENTURE CIRCLE
NASHVILLE, TN 37228

OTHER COVERAGE

2. OTHER DENTAL OR MEDICAL COVERAGE? ☐ NO IF NO, SKIP TO **#11** ☐ YES

3. AMOUNT OF PRIMARY PAYMENT **$**

4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP

5. DATE OF BIRTH

6. GENDER ☐ M ☐ F

7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)

8. PLAN/GROUP NUMBER

9. RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME

SUBSCRIBER INFORMATION

11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP

12. DATE OF BIRTH

13. GENDER ☐ M ☐ F

14. SUBSCRIBER ID (SSN OR ID#)

15. PLAN/GROUP NUMBER

16. EMPLOYER NAME

PATIENT INFORMATION

17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)

18. RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

19. DATE OF BIRTH

20. GENDER ☐ M ☐ F

21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS ☐ FULL TIME STUDENT ☐ TOTALLY & PERM DISABLED ☐ IRS DEPENDENT ☐ SPONSORED DEPENDENT

DENTAL SERVICES

	22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION	28. FEE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH	PERMANENT																PRIMARY										29. TOTAL FEE CHARGED
30. PLACE **X** ON MISSING TOOTH NUMBERS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

REMARKS

31.

AUTHORIZATIONS

32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.

PATIENT/GUARDIAN SIGNATURE DATE

33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.

SUBSCRIBER SIGNATURE DATE

ADDITIONAL CLAIM INFORMATION

34. PLACE OF TREATMENT ☐ DENTAL OFFICE ☐ HOSPITAL ☐ ECF ☐ OTHER

35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____

36. IS TREATMENT RELATED TO ORTHODONTICS? ☐ NO ☐ YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____

37. TREATMENT RESULTING FROM: ☐ OCCUPATIONAL ILLNESS/INJURY ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT

38. REPLACEMENT OF PROSTHESIS? ☐ YES DATE PRIOR PLACEMENT _____ ☐ NO

BILLING DENTIST/DENTAL ENTITY (#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)

39. NAME, ADDRESS, CITY, STATE, ZIP

40. NPI

41. LICENSE NUMBER

42. TIN

43. PHONE NUMBER ( )

TREATING DENTIST AND LOCATION

44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO PREDETERMINE THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGEMENT.

X _____
SIGNED (TREATING DENTIST) DATE

45. NPI

46. LICENSE NUMBER

47. TIN

48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)

49. PHONE NUMBER ( )

50. ADDITIONAL DENTIST ID

51. SPECIALTY CODE