



Delta Dental Plan of Iowa

P.O. Box 919 • Ankeny, Iowa 50021-0919

ATTENDING DENTIST'S STATEMENT	PATIENT ACCOUNT NUMBER
<input type="checkbox"/> PRETREATMENT REQUEST <input type="checkbox"/> SETTLEMENT OF ACTUAL SERVICES	_____

PATIENT SECTION

1. PATIENT NAME (LAST) _____ (FIRST) _____ (INITIAL) _____			2. RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		
3. SEX <input type="checkbox"/> M <input type="checkbox"/> F	4. PATIENT BIRTH DATE MONTH DAY YEAR	5. IF FULL TIME 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, ZIP CODE)			9. EMPLOYER NAME AND ADDRESS (STREET, CITY, STATE, ZIP)		
10. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> 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 PROVIDER NUMBER	15. DENTIST PHONE NUMBER		18. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER	DATE APPLIANCES PLACED	MONTHS TREATMENT REMAINING

EXAMINATION 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 _____ 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		