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

DENTAL CLAIM FORM

ATTENDING DENTIST'S STATEMENT
☐ PRETREATMENT REQUEST
☐ SETTLEMENT OF ACTUAL SERVICES

PATIENT ACCOUNT NUMBER

PATIENT SECTION

1. PATIENT NAME (LAST) (FIRST) (INITIAL)

2. RELATIONSHIP TO SUBSCRIBER
☐ SELF ☐ SPOUSE ☐ DEPENDENT

3. SEX
☐ M ☐ F

4. PATIENT BIRTH DATE YEAR MONTH DAY

5. IF FULL TIME STUDENT ☐ YES ☐ NO

6. SUBSCRIBER NAME (LAST) (FIRST) (INITIAL)

7. SUBSCRIBER IDENTIFICATION 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?
☐ 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

PLEASE PROVIDE TOOTH NUMBERS WHERE REQUIRED

DENTIST SECTION

11. DENTIST NAME

12. ADDRESS (STREET, CITY, STATE, ZIP)

13. TAX I.D. NUMBER

14. DENTIST PROVIDER NUMBER

15. DENTIST PHONE NUMBER

16. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY?
☐ YES ☐ NO

17. IS TREATMENT A RESULT OF AUTO ACCIDENT?
☐ YES ☐ NO

18. IS TREATMENT FOR ORTHODONTICS?
☐ YES ☐ NO

19. PLACE OF TREATMENT
☐ OFFICE ☐ HOSPITAL ☐ OTHER

EXAMINATION AND TREATMENT RECORD

LIST IN ORDER FROM TOOTH #1 THROUGH TOOTH #32

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

PC-001 • 12/98