



**Delta Dental of Delaware**  
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 TTY/TDD 888-373-3582  
 www.MidAtlanticDeltaDental.com

**ATTENDING DENTIST'S STATEMENT**

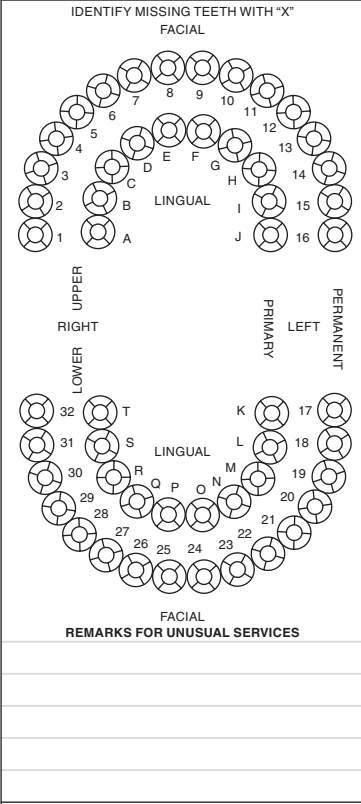
SIGN BELOW  
 FOR PREDETERMINATION \*  
 OR PAYMENT \*\*

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F		<b>IMPORTANT</b> 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		<b>IMPORTANT</b> 7. SUBSCRIBER I.D. NUMBER		OR 1 _____ OR 2 _____ OR 3 _____ OR 4 _____ OR 5 _____ OR 6 _____	
8. EMPLOYEE HOME ADDRESS		CITY, STATE ZIP		ZIP CODE		9. EMPLOYER (COMPANY) NAME AND ADDRESS					
10. GROUP NUMBER		<b>IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15</b>		11. DELTA - COVERED EMPLOYEE BIRTHDATE MO. DAY YR.		12. SPOUSE NAME		13. SPOUSE BIRTHDATE MO. DAY YR.		15. SPOUSE I.D. NUMBER	
14. NAME AND ADDRESS OF CARRIER											

DENTIST NAME		Mailing Address		CITY, STATE ZIP		DENTIST I.D. NUMBER		DENTIST LICENSE		DENTIST PHONE NO.		FIRST VISIT DATE CURRENT SERIES		PLACE OF TREATMENT OFFICE OTHER		RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		HOW MANY?		DATE OF PRIOR PLACEMENT		IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES		IF YES, ENTER BRIEF DESCRIPTION AND DATES		IS TREATMENT RESULT OF AUTO ACCIDENT? NO YES		OTHER ACCIDENT?		IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO YES		IF NO, ENTER REASON FOR REPLACEMENT		IS TREATMENT FOR ORTHODONTICS? NO YES		IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING	
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EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.										
TOOTH # OR LETTER	SURFACES MOJ DLF	Description Of Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YR.			ADA PROCEDURE NUMBER	FEE			
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Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

\* PREDETERMINATION OF COSTS  
 THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS

DENTIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\*\* 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 \_\_\_\_\_

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		
PATIENT PAYS		
DELTA PAYS		
AMOUNT APPLIED TO DEDUCTIBLE		

FORM DD/DE-0016-04-10