Delta Dental of New York
P.O. Box 2105
Mechanicsburg, PA 17055-2105
(800) 471-7093
TTY/TDD 888-373-3582
www.deltadentalins.com/uup

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

IMPORTANT
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

IMPORTANT
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

UUP Benefit Trust Fund - Active Members

10. GROUP NUMBER

0165

IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15

11. DELTA - COVERED EMPLOYEE BIRTHDATE: MO. / DAY / YR.

12. SPOUSE NAME

13. SPOUSE BIRTHDATE: MO. / DAY / YR.

14. NAME AND ADDRESS OF CARRIER

15. SPOUSE I.D. NUMBER

DENTIST NAME

MAILING ADDRESS

CITY, STATE ZIP

	NO	YES	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, ENTER REASON FOR REPLACEMENT

DATE OF PRIOR PLACEMENT

DENTIST I.D. NUMBER | DENTIST LICENSE | DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES

PLACE OF TREATMENT: OFFICE / OTHER

RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ — HOW MANY?

	NO	YES
IS TREATMENT FOR ORTHODONTICS?		

IF SERVICES ALREADY COMMENCED, ENTER:

DATE APPLIANCES PLACED

MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"

FACIAL

UPPER: 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

LINGUAL

RIGHT — LEFT — PRIMARY — PERMANENT

LOWER: 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32; K L M N O P Q R S T

LINGUAL

FACIAL

EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO.	DAY	YR.	ADA PROCEDURE NUMBER	FEE
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					
		16					
		17					
		18					
		19					
		20					

REMARKS FOR UNUSUAL SERVICES

Pursuant to law, please be advised that any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

* 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/NY-0016-04-10