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 Member Services Trust Fund - Part Timers

10. GROUP NUMBER
0166

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

	NO	YES
IS TREATMENT FOR ORTHODONTICS?		

IF SERVICES ALREADY COMMENCED, ENTER:
DATE APPLIANCES PLACED
MONTHS TREATMENT REMAINING

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?

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: 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
LINGUAL
FACIAL

REMARKS FOR UNUSUAL SERVICES

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						

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	