DELTA DENTAL®

One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

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
4. PATIENT BIRTHDATE: MO. | DAY | YEAR
5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL / CITY

6. EMPLOYEE/ SUBSCRIBER NAME: LAST | FIRST | MIDDLE INT.
7. EMPLOYEE SOCIAL SECURITY NUMBER

8. EMPLOYEE HOME ADDRESS
CITY, STATE ZIP
ZIP CODE

9. EMPLOYER (COMPANY) NAME AND ADDRESS
Masters, Mates & Pilots Health and Benefits Plan

OR 1 _____
OR 2 _____
OR 3 _____
OR 4 _____
OR 5 _____
OR 6 _____

10. GROUP NUMBER
7117

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

11. DELTA – COVERED EMPLOYEE BIRTH DATE: MO. | DAY | YEAR

12. SPOUSE NAME

13. SPOUSE BIRTHDATE: MO. | DAY | YEAR

14. NAME AND ADDRESS OF CARRIER

15. SPOUSE SOCIAL SECURITY NUMBER

DENTIST NAME

MAILING ADDRESS

CITY, STATE ZIP

DENTIST SOC. SEC. NO. OR FED. IDENT. NO.

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 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

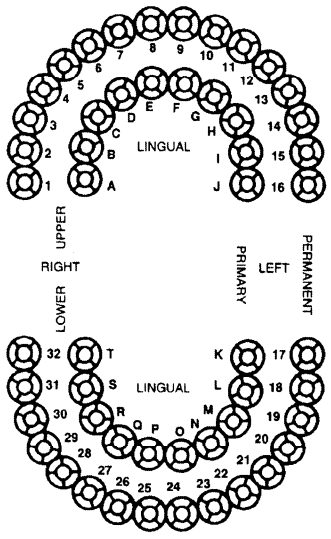
IS TREATMENT FOR ORTHODONTICS? NO | YES

IF SERVICES ALREADY COMMENCED, ENTER:

DATE APPLIANCES PLACED

MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



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 Service 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			

DIRECTION TO PAY BENEFITS TO DENTIST

I hereby direct benefits payable to the attending dentist.

Employee: _____

Signature: _____ Date: _____

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

DENTIST SIGNATURE DATE

**** TREATMENT COMPLETED – PAYMENT REQUESTED**
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, 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/DC-0016-97-07