Dental Claim Form

See reverse for instructions

DELTA DENTAL
Delta Dental Plan of Arizona

1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

AZ

Delta Dental Plan of Arizona
P.O. Box 43026
Phoenix, AZ 85080-3026

PATIENT COVERAGE INFORMATION

4. Patient name first m.i. last ☐ Check here if disabled
5. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other _____
6. Sex m f
7. Patient birthdate MM DD YYYY
8. If full time student, print school and attach student enrollment documentation (see instructions on reverse).
9. Employee/subscriber name and mailing address
10. Employee/subscriber social security number
11. Employee/subscriber birthdate MM DD YYYY
12. Employer (company) name and address MARICOPA COUNTY
13. Group number
14. Is patient covered by another dental plan? yes no
If yes, complete 15-a.
Is patient covered by a medical plan for any of the services listed on this form? yes no
15-a. Name and address of carrier(s)
15-b. Group no.(s)
16. Name and address of other employer(s)
17-a. Employee/subscriber name (if different from patient's)
17-b. Employee/subscriber social security number
17-c. Employee/subscriber birthdate
18. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other _____

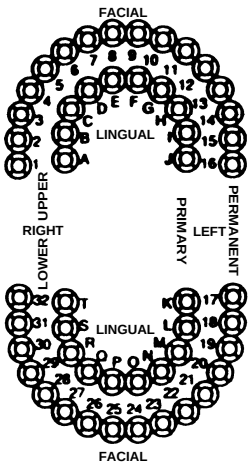
19. **I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.**

Signed (Patient* – see reverse) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity
22. Address where payment should be remitted
23. City, State, Zip
24. Dentist Soc. Sec. or T.I.N. (see reverse**)
25. Dentist license no.
26. Dentist phone no.
27. First visit date current series
28. Place of treatment Office Hosp. ECF Other
29. Radiographs or models enclosed? No Yes How many?
30. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates
31. Is treatment result of auto accident?
32. Other accident?
33. If prosthesis, is this initial placement? (If no, reason for replacement)
34. Date of prior placement
35. Is treatment for orthodontics? If service already commenced, enter: Date appliances placed Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan – List in treatment plan order – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.) If services exceed 15 line items, please complete separate form.	Date service Completed Mo. Day Year	Procedure Code	Fee

For Delta use only

38. Remarks for unusual services

39. **I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. For pre-treatment estimates, the fees submitted are the actual fees I intend to collect for those procedures.**

Print Name of Treating Dentist Signature of Treating Dentist License Number Date

41. **Total Fee Charged** $0.00
42. **Payment by other plan**
Max. Allowable
Deductible
Carrier %
Carrier pays
Patient pays

FOR CLAIMS AND BENIFIT INFORMATION, CONTACT:
DAISY (Delta's Automated Information System)
602-938-3131 ext 1 or 1-800-352-6132 ext 1

CUSTOMER SERVICE
602-938-3131 ext 2 or 1-800-352-6132 ext 2