



DENTAL CLAIM FORM

Delta Dental of Iowa
P.O. Box 9000
Johnston, Iowa 50131-9000
800-544-0718

PATIENT SECTION

ATTENDING DENTIST'S STATEMENT		PATIENT ACCOUNT NUMBER	
☐ PRETREATMENT REQUEST ☐ STATEMENT OF ACTUAL SERVICES			
1. PATIENT NAME (LAST) (FIRST) (INITIAL)		2. RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
3. SEX ☐ M ☐ F	4. PATIENT BIRTH DATE MONTH DAY YEAR	5. IF FULL TIME STUDENT	6. SUBSCRIBER IDENTIFICATION NUMBER
6. SUBSCRIBER NAME (LAST) (FIRST) (INITIAL)		7. SUBSCRIBER HOME PHONE NUMBER () SUBSCRIBER WORK PHONE NUMBER ()	
8. SUBSCRIBER ADDRESS (STREET OR RFD NUMBER, CITY, STATE, ZIP CODE)		9. EMPLOYER NAME AND ADDRESS (STREET, CITY, STATE, ZIP)	
10. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO		DENTAL PLAN NAME UNION LOCAL GROUP NUMBER	
NAME AND ADDRESS OF OTHER INSURANCE COMPANY			
I hereby accept the treatment below and authorize release of any information relating to this claim.			
PATIENT/PARENT OR EMPLOYEE-MEMBER SIGNATURE X DATE			

DENTIST SECTION

PLEASE PROVIDE TOOTH NUMBERS WHEN REQUIRED

11. DENTIST NAME AND ADDRESS (STREET, CITY, STATE, ZIP)		16. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY?	YES	NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
		17. IS TREATMENT A RESULT OF AUTO ACCIDENT?				
		OTHER ACCIDENT?				
12. NPI	13. DENTIST LICENSE NUMBER	14. TAX ID NUMBER				
15. PHONE NUMBER		18. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER	DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING
		19. IF PROTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT	20. DATE OF PRIOR PLACEMENT

DIAGNOSTIC AND TREATMENT RECORD

LIST IN TOOTH ORDER (1 - 32 OR A - T)

ARE X-RAYS OR OTHER REVIEW DOCUMENTS ATTACHED? ☐ YES ☐ NO

21. PLACE OF TREATMENT ☐ OFFICE ☐ HOSPITAL ☐ OTHER

TOOTH # OR LETTER	QUAD	SURFACES	DESCRIPTION OF SERVICE	COMPLETION DATE MONTH / DATE / YEAR	PROCEDURE CODE	CHARGE
			1.)			
			2.)			
			3.)			
			4.)			
			5.)			
			6.)			
			7.)			
			8.)			
			9.)			

22. IDENTIFY ALL MISSING TEETH WITH AN X:

PERMANENT																PRIMARY									
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
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

I hereby certify that the services listed above have been completed and to the best of my knowledge are within the provisions of the plan, payment is therefore due.

TREATING DENTIST SIGNATURE X DATE

LICENSE NUMBER NPI

TOTAL

LESS THIRD PARTY PAYMENTS

NET CHARGE