DELTA DENTAL®

Dental Claim Form

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

PATIENT SECTION

1. TYPE OF TRANSACTION
- ☐ PRE-DETERMINATION/PRIOR AUTHORIZATION
- ☐ STATEMENT OF ACTUAL SERVICES
- ☐ EPSDT / TITLE XIX

2. PRE-DETERMINATION/ PRIOR AUTHORIZATION NUMBER

3. PATIENT ACCOUNT NUMBER

4. PATIENT NAME (LAST) (FIRST) (INITIAL)

5. RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

6. SEX ☐ M ☐ F ☐ U

7. PATIENT BIRTH DATE (MM/DD/YYYY)

8. IF FULL TIME STUDENT CITY STATE

POLICYHOLDER/SUBSCRIBER SECTION

9. POLICYHOLDER/SUBSCRIBER NAME (LAST) (FIRST) (MIDDLE INITIAL)

10. SUBSCRIBER IDENTIFICATION NUMBER

11. POLICYHOLDER/SUBSCRIBER BIRTH DATE (MM/DD/YYYY)

12. POLICYHOLDER/SUBSCRIBER HOME PHONE AND WORK PHONE ( ) ( )

13. SEX ☐ M ☐ F ☐ U

14. SUBSCRIBER ADDRESS (STREET, CITY, STATE, ZIP CODE)

15. IS THE PATIENT COVERED BY ANOTHER DENTAL/MEDICAL PLAN? ☐ YES ☐ NO

16. NAME OF POLICYHOLDER/SUBSCRIBER IN #14 (LAST, FIRST, INITIAL)

17. DENTAL PLAN NAME UNION LOCAL GROUP NUMBER

18. ID NUMBER

19. RELATIONSHIP TO POLICYHOLDER/SUB ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

20. BIRTH DATE (MM/DD/YYYY)

21. SEX ☐ M ☐ F ☐ U

22. NAME AND ADDRESS OF INSURANCE COMPANY

I hearby accept the treatment below and authorize release of any information relating to this claim.

PATIENT/PARENT OR SUBSCRIBER SIGNATURE X_____ DATE _____

DENTIST SECTION

23. DENTIST NAME AND ADDRESS (STREET, CITY, STATE, ZIP)

24. NPI

25. DENTIST LICENSE #

26. TAX ID #

27. PHONE NUMBER

PLEASE PROVIDE TOOTH NUMBERS WHEN REQUIRED

	YES	NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES
28. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY?	☐	☐	
29. IS TREATMENT A RESULT OF AUTO ACCIDENT?	☐	☐	
OTHER ACCIDENT?	☐	☐	
30. IS TREATMENT FOR ORTHODONTICS?	☐	☐	IF SERVICES ALREADY COMMENCED ENTER — DATE APPLIANCES PLACED — MONTHS TREATMENT REMAINING
31. IF PROSTHESIS, IS THIS INITIAL PLACEMENT	☐	☐	IF NO, REASON FOR REPLACEMENT — 24. DATE OF PRIOR PLACEMENT

DIAGNOSTIC AND TREATMENT RECORD

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

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

33. PLACE OF TREATMENT ☐ OFFICE ☐ HOSPITAL ☐ OTHER

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

34. IDENTIFY ALL MISSING TEETH WITH AN X:

PERMANENT: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

PRIMARY: A B C D E F G H I J / T R S Q P O N M L K

TOTAL	$ 0 00
LESS THIRD PARTY PAYMENT	
NET CHARGES	$ 0 00

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

TREATING DENTIST SIGNATURE X_____ DATE_____

LICENSE NUMBER_____ NPI _____