

TYPE OR PRINT

RETAIN THE COPY FOR YOUR FILES. MAIL THE ORIGINAL TO PLAN.

STAPLE X-RAYS TO TOP RIGHT CORNER OF FORMS.

SHADED AREAS FOR DELTA USE ONLY



DELTA USE ONLY  
P.O. Box 7736  
San Francisco, California 94120-7736

Delta Dental Plan of California



PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME FIRST MIDDLE LAST			2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F	4. PATIENT BIRTHDATE MO DAY YEAR		5. IF FULL TIME STUDENT AND OVER AGE 18, INDICATE: SCHOOL CITY	
6. EMPLOYEE/SUBSCRIBER NAME			7. EMPLOYEE SOCIAL SECURITY NUMBER		8. EMPLOYEE BIRTHDATE MO DAY YEAR		9. EMPLOYER (COMPANY) NAME AND ADDRESS/ UNION LOCAL		10. GROUP NUMBER
EMPLOYEE MAILING ADDRESS			APT. NO.		PHONE NO.		CITY, STATE, ZIP		ZIP CODE
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES NO			12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.		12b. GROUP NUMBER		13. NAME AND ADDRESS OF EMPLOYER, ITEM 11		
14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)			14b. EMPLOYEE SOCIAL SECURITY NUMBER		14c. EMPLOYEE BIRTHDATE MO DAY YEAR		15. RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER		
16. DENTIST NAME			LICENSE NUMBER		24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO YES IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.		
17. MAILING ADDRESS			PHONE NO.		25. IS TREATMENT RESULT OF AUTO ACCIDENT?		26. OTHER ACCIDENT?		
CITY, STATE, ZIP			ZIP CODE		27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?				
18. DENTIST SOC. SEC. NO. OR T.I.N.		19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.		29. DATE OF PRIOR PLACEMENT	
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES		30. IS TREATMENT FOR ORTHODONTICS? NO YES		IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

TOOTH NO. OR LETTER	SUR-FACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED			PROCEDURE NUMBER	FEE
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32. REMARKS FOR UNUSUAL SERVICES OR AMOUNT PAID BY OTHER COVERAGE

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE.  
SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) \_\_\_\_\_ DATE \_\_\_\_\_  
You may receive a copy of this authorization on request.

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	
PAYMENT SUBJECT TO PERCENT WITHHOLD AS APPROVED BY PLAN BOARD OF DIRECTORS.	

**PREDETERMINATION OF COST**  
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST AUTHORIZATION IN ACCORDANCE WITH DELTA PARTICIPATING DENTIST RULES.  
DENTIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**TREATMENT COMPLETED - PAYMENT REQUESTED**  
THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM.  
DENTIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

ATTENDING DENTIST'S STATEMENT  
DELTA 105 Rev. 8/97

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1. SUBMIT TO DELTA  
2. RETAIN FOR YOUR FILES



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