


DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION																											
1. <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES <input type="checkbox"/> PREDETERMINATION REQUEST																											
	DELTA DENTAL OF COLORADO P.O. BOX 173803 DENVER, CO 80217-2528																										
OTHER COVERAGE																											
2. OTHER DENTAL OR MEDICAL COVERAGE? <input type="checkbox"/> NO IF NO, SKIP TO #11 <input type="checkbox"/> YES	3. AMOUNT OF PRIMARY PAYMENT \$																										
4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																											
SUBSCRIBER INFORMATION																											
11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																											
12. DATE OF BIRTH	13. GENDER <input type="checkbox"/> M <input type="checkbox"/> F																										
14. SUBSCRIBER ID (SSN OR ID#)																											
15. PLAN/GROUP NUMBER	16. EMPLOYER NAME																										
PATIENT INFORMATION																											
5. DATE OF BIRTH																											
6. GENDER <input type="checkbox"/> M <input type="checkbox"/> F	7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)																										
8. PLAN/GROUP NUMBER	9. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER																										
17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)																											
18. RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	19. DATE OF BIRTH																										
20. GENDER <input type="checkbox"/> M <input type="checkbox"/> F																											
10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME																											
21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> TOTALLY & PERM DISABLED <input type="checkbox"/> IRS DEPENDENT <input type="checkbox"/> SPONSORED DEPENDENT																											
DENTAL SERVICES																											
22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION	28. FEE																					
1																											
2																											
3																											
4																											
5																											
6																											
7																											
8																											
9																											
10																											
MISSING TEETH		PERMANENT										PRIMARY										29. TOTAL FEE CHARGED					
30. PLACE X ON MISSING TOOTH NUMBERS		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
REMARKS																											
31.																											
AUTHORIZATIONS														ADDITIONAL CLAIM INFORMATION													
32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.														34. PLACE OF TREATMENT <input type="checkbox"/> DENTAL OFFICE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ECF <input type="checkbox"/> OTHER													
PATIENT/GUARDIAN SIGNATURE _____ DATE _____														35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____													
33. WHERE PERMITTED BY LAW, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.														36. IS TREATMENT RELATED TO ORTHODONTICS? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____													
SUBSCRIBER SIGNATURE _____ DATE _____														37. TREATMENT RESULTING FROM: <input type="checkbox"/> OCCUPATIONAL ILLNESS/INJURY <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER ACCIDENT													
														38. REPLACEMENT OF PROSTHESIS? <input type="checkbox"/> YES DATE PRIOR PLACEMENT _____ <input type="checkbox"/> NO													
BILLING DENTIST/DENTAL ENTITY <small>(#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)</small>														TREATING DENTIST AND LOCATION													
39. NAME, ADDRESS, CITY, STATE, ZIP														44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO PREDETERMINE THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGEMENT.													
														<input checked="" type="checkbox"/> _____ SIGNED (TREATING DENTIST) _____ DATE _____													
40. NPI				41. LICENSE NUMBER				42. SSN OR TIN				45. NPI				46. LICENSE NUMBER				47. SSN OR TIN							
43. PHONE NUMBER ()														48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #33)													
49. PHONE NUMBER ()														50. ADDITIONAL DENTIST ID				51. SPECIALTY CODE									

For the fastest processing, submit claims electronically through our **Dental Office Toolkit!**
It's free, easy, and available to all dentists. Check our Web site for more information.

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- Clearly type, hand write, or use a computer printer to enter information.
- Use all upper-case (capital) letters, if possible.
- Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.
- Keep information within the correct field.
- Make sure the typewriter or printer ribbon is dark and the print can be easily read.
- Cover mistakes with line tape and print or type over—do not use liquid correction fluid.
- Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter \$0 unless the primary carrier's determination of payment was \$0. DO NOT ATTACH the primary carrier's voucher.
- Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- Hand or machine print
- When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).
- Use current ADA CDT procedure codes.
- Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.

FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.
- Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.
- Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS AND INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO	WEB SITE
Delta Dental of Colorado P.O. Box 173803 Denver, CO 80217-2528	(800) 610-0201	www.deltadentalco.com