# DELTA DENTAL

Delta Dental of New York

One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

## ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION *
OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME

2. RELATIONSHIP TO EMPLOYEE — SELF | SPOUSE | CHILD | OTHER

3. SEX — M | F

4. PATIENT BIRTHDATE (IMPORTANT) — MO. | DAY | YEAR

5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL / CITY

6. EMPLOYEE/ SUBSCRIBER NAME — LAST / FIRST / MIDDLE INT.

7. EMPLOYEE SOCIAL SECURITY NUMBER (IMPORTANT)

8. EMPLOYEE HOME ADDRESS

CITY, STATE ZIP — ZIP CODE

9. EMPLOYER (COMPANY) NAME AND ADDRESS

City of Schenectady

OR 1 _____
OR 2 _____
OR 3 _____
OR 4 _____
OR 5 _____
OR 6 _____

10. GROUP NUMBER

2332

IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15

11. DELTA - COVERED EMPLOYEE BIRTHDATE — MO. | DAY | YEAR

12. SPOUSE NAME

13. SPOUSE BIRTHDATE — MO. | DAY | YEAR

14. NAME AND ADDRESS OF CARRIER

15. SPOUSE SOCIAL SECURITY NUMBER

DENTIST NAME

MAILING ADDRESS

CITY, STATE ZIP

DENTIST SOC. SEC. NO. OR FED. IDENT. NO.

DENTIST LICENSE

DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES

PLACE OF TREATMENT — OFFICE | OTHER

RADIOGRAPHS OR MODELS ENCLOSED? — NO ☐ YES ☐

HOW MANY?

| | NO | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES |
|---|---|---|---|
| IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | | | |
| IS TREATMENT RESULT OF AUTO ACCIDENT? | | | |
| OTHER ACCIDENT? | | | |
| IF PROSTHESIS, IS THIS INITIAL PLACEMENT? | | | IF NO, ENTER REASON FOR REPLACEMENT |

DATE OF PRIOR PLACEMENT

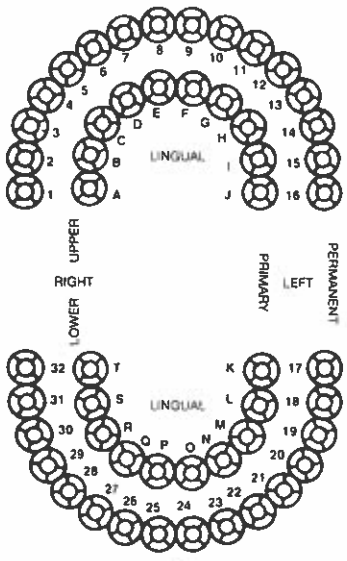
IS TREATMENT FOR ORTHODONTICS? — NO | YES

IF SERVICES ALREADY COMMENCED, ENTER:

DATE APPLIANCES PLACED

MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"




REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.

| TOOTH # OR LETTER | SURFACES MOI DLF | Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc. | DATE SERVICE PERFORMED MO. DAY YR. | ADA PROCEDURE NUMBER | FEE |
|---|---|---|---|---|---|
| | | | | | |

Pursuant to law, please be advised that any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

* **PREDETERMINATION OF COSTS**
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS

DENTIST SIGNATURE — DATE

** **TREATMENT COMPLETED – PAYMENT REQUESTED**
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.

DENTIST SIGNATURE — DATE

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.

PATIENT SIGNATURE _____

DATE _____

| | |
|---|---|
| TOTAL FEE CHARGED | |
| PATIENT PAYS | |
| DELTA PAYS | |
| AMOUNT APPLIED TO DEDUCTIBLE | |

FORM DD/NY-0016-01-03