DELTA DENTAL
Delta Dental Plan of Wisconsin
P.O. Box 828, Stevens Point, WI 54481 • 800-236-3712

ATTENDING DENTIST'S STATEMENT

1. PATIENT NAME

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

3. SEX: M | F

4. PATIENT BIRTHDATE: MO. | DAY | YEAR

5. FULL TIME STUDENT IF OVER AGE 18: SCHOOL | CITY

6. EMPLOYEE / SUBSCRIBER NAME: FIRST | MIDDLE | LAST

7. EMPLOYEE SOCIAL SEC. NO.

8. EMPLOYEE MAILING ADDRESS

CITY, STATE, ZIP

9. EMPLOYEE BIRTH DATE

10. EMPLOYER (COMPANY) NAME AND ADDRESS

11. GROUP NUMBER

12. LOCATION (LOCAL)

13. IF SPOUSE IS EMPLOYED: NAME | SOCIAL SECURITY NO. | BIRTH DATE

14. NAME AND ADDRESS OF EMPLOYER, ITEM 13

15. DOES PATIENT HAVE OTHER COVERAGE? | DENTAL PLAN NAME | GROUP NUMBER | NAME AND ADDRESS OF CARRIER

16. DENTIST NAME

17. MAILING ADDRESS

CITY, STATE, ZIP

23. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO | YES

24. IS TREATMENT RESULT OF AUTO ACCIDENT? NO | YES

25. OTHER ACCIDENT? NO | YES

26. ARE ANY SERVICES COVERED BY ANOTHER PLAN? NO | YES

IF YES, ENTER BRIEF DESCRIPTION AND DATES

18. DENTIST SOC. SEC. NO. OR T.I.N.

19. DENTIST LICENSE NO.

20. DENTIST PHONE NO.

27. IS THIS FIRST PROSTHESIS FOR THIS AREA? IF NO, ENTER REASON FOR REPLACEMENT: NO | YES

28. DATE OF PRIOR PLACEMENT

21. PLACE OF TREATMENT: OFFICE | HOSPITAL | ECF | OTHER

22. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY

29. IS THE TREATMENT FOR ORTHODONTICS? NO | YES

IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED

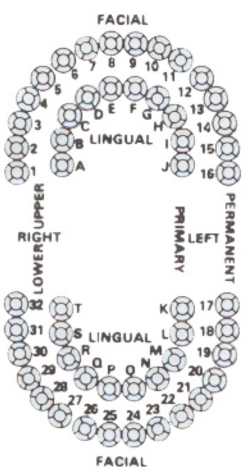
MOS. TREATMENT REMAINING

CHECK ONE:

☐ PREDETERMINATION OF BENEFITS

☐ CLAIM FOR PAYMENT

IDENTIFY MISSING TEETH WITH "X"



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

TOOTH # OR LETTER	SURFACES	CI	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED MO.	DAY	YEAR		ADA CODE PROCEDURE NUMBER	FEE CHARGED	PLAN USE

31. REMARKS FOR UNUSUAL SERVICES

TOTALS	
DELTA PAYS	
PATIENT PAYS	
DEDUCTIBLE	

TREATMENT COMPLETED — PAYMENT REQUESTED

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY THE DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

DENTIST SIGNATURE ______________________ DATE ______________

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY THE TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.

PATIENT (PARENT OR EMPLOYEE SIGNATURE) X ______________________

CROWN INFORMATION: (CI ABOVE)

A. ENDO TOOTH
B. BROKEN TH/CUSP
C. PERIO SPLINT
D. CONTOUR
E. REM. PROS. ABUTMENT
F. NEW CARIES
G. ESTHETICS
H. MASS. AMAL. FAIL
I. ABRASION
J. OCCLUSION

PATIENT Signature Required - DENTIST Signature Required on Claim for Payment

GRAY SHADED AREAS FOR DELTA USE ONLY.

MAIL TOP COPY TO PLAN. RETAIN LAST COPY FOR YOUR FILES.

RADIOGRAPHS REQUIRED FOR PREDETERMINATION OF BENEFITS (SPECIAL SERVICE). **MOUNT AND STAPLE TO BACK SIDE OF FORM.**

SUBMIT TO DELTA

1097AP50KCLCNT