



Delta Dental Plan of Colorado

P.O. Box 173803
Denver, CO 80217-3803
303-741-9300
800-233-0860

Customer Relations
303-741-9305
800-610-0201

1. PATIENT NAME - PLEASE PRINT
2. RELATIONSHIP TO EMPLOYEE
3. SEX
4. PATIENT BIRTHDATE
5. IF FULL TIME STUDENT OVER AGE 18
6. EMPLOYEE/SUBSCRIBER NAME
7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS
9. EMPLOYEE/SUBSCRIBER BIRTHDATE
10. NAME OF EMPLOYER, UNION OR TRUST FUND
11. EMPLOYER ADDRESS
12. GROUP NUMBER
13. UNION LOCAL NO.
14. IS PATIENT COVERED BY ANOTHER PLAN?
15. IF YES, ATTACH PRIMARY CARRIER PAYMENT EXPLANATION.
16. LIST OTHER FAMILY MEMBERS EMPLOYED WITH BENEFIT COVERAGE.

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL HISTORY, CONDITION OR TREATMENT, AS NEEDED TO DETERMINE BENEFITS RELATED TO THE DENTAL WORK FOR WHICH THIS CLAIM IS MADE. I UNDERSTAND AND AGREE WITH THE TREATMENT RECOMMENDED AND SUBMITTED ON THIS FORM. I CERTIFY THAT THE INFORMATION IN BLOCKS 1 THROUGH 17 IS TRUE AND CORRECT.

17. SIGNATURE OF PATIENT
18. DENTIST NAME
19. MAILING ADDRESS
20. DENTIST SOC. SEC. NO. OR TAX ID NO.
21. DENTIST LICENSE NO.
22. DENTIST PHONE NO.
23. PREDETERMINATION
24. PAR N PAR
25. RADIOGRAPHS OR MODELS ENCLOSED?
26. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?
27. IS TREATMENT RESULT OF AUTO ACCIDENT?
28. OTHER ACCIDENT?
29. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?
30. IS TREATMENT FOR ORTHODONTICS?

31. EXAMINATION AND TREATMENT PLAN - USE CHARTING SYSTEM SHOWN
Table with columns: TOOTH OR QUAD, SURFACE, DESCRIPTION OF SERVICE, DATE SERVICE PERFORMED, PROCEDURE NUMBER, DENTIST FEE, FOR DELTA USE ONLY. Includes a dental chart diagram.

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.
33. DENTIST'S SIGNATURE
DATE
TOTAL FEE CHARGED

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental Plan of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts to Delta participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

ATTENDING DENTIST'S STATEMENT