DELTA DENTAL®

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 FIRST	LAST	2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER	3. SEX M F	4. PATIENT BIRTHDATE MO DAY YR	5. IF FULL TIME STUDENT OVER AGE 18 CITY, STATE SCHOOL NAME

6. EMPLOYEE/SUBSCRIBER NAME FIRST	LAST	7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.	10. NAME OF EMPLOYER, UNION OR TRUST FUND	JAN	FEB
				MAR	APR
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS		9. EMPLOYEE/SUBSCRIBER BIRTHDATE	11. EMPLOYER ADDRESS	MAY	JUN
				JUL	AUG
CITY	STATE	ZIP		SEP	OCT
				NOV	DEC

12. GROUP NUMBER	13. UNION LOCAL NO.	14. IS PATIENT COVERED BY ANOTHER PLAN? NO ☐ YES ☐	15. IF YES, ATTACH PRIMARY CARRIER PAYMENT EXPLANATION. NO ☐ YES ☐

16. LIST OTHER FAMILY MEMBERS EMPLOYED WITH BENEFIT COVERAGE. EMPLOYEE NAME	RELATIONSHIP	SOC. SEC. NO.	BIRTHDATE MO DAY YR	DENTAL PLAN NAME	GROUP NO.

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.

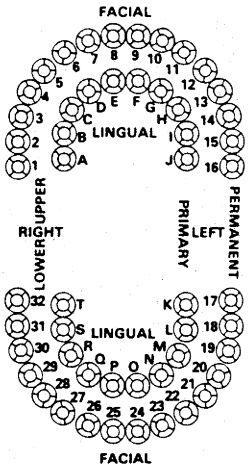
17.SIGNATURE OF PATIENT
(or parent or guardian) _____ DATE _____

18. DENTIST NAME	26. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES.
19. MAILING ADDRESS	27. IS TREATMENT RESULT OF AUTO ACCIDENT?			
CITY / STATE / ZIP	28. OTHER ACCIDENT?			

20. DENTIST SOC. SEC. NO. OR TAX ID NO.	21. DENTIST LICENSE NO. STATE	22. DENTIST PHONE NO. ( )	29. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		IF NO, REASON FOR REPLACEMENT?	DATE OF PRIOR PLACEMENT.

23. PREDETERMINATION NO ☐ YES ☐	24. PAR N PAR	25. RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?	30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED.	MOS TREATMENT REMAINING.

IDENTIFY MISSING TEETH WITH "X"



32 REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN — USE CHARTING SYSTEM SHOWN

TOOTH OR QUAD	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	DENTIST FEE	FOR DELTA USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

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

4/97