DELTA DENTAL®

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization

CARRIER NAME AND ADDRESS:

2. Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

4. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

5. Date of Birth (MM/DD/CCYY)	6. Gender ☐ M ☐ F	7. Subscriber Identifier (SSN or ID#)

8. Plan/Group Number	9. Employer Name
5436	University of Illinois

PATIENT INFORMATION

10. Relationship to Primary Subscriber (Check applicable box)	11. Student Status
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	☐ FTS ☐ PTS

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Patient ID/Account # (Assigned by Dentist)

OTHER COVERAGE

16. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

17. Subscriber Name (Last, First, Middle Initial, Suffix)

18. Date of Birth (MM/DD/CCYY)	19. Gender ☐ M ☐ F	20. Subscriber Identifier (SSN or ID#)

21. Plan/Group Number	22. Relationship to Primary Subscriber (Check applicable box)
	☐ Self ☐ Spouse ☐ Dependent ☐ Other

23. Other Carrier Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
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

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99)
Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?
☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis?
☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID	50. License Number	51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

54. Provider ID	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty