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

IMPORTANT
4. PATIENT BIRTHDATE: MO. | DAY | YEAR

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

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

IMPORTANT
7. EMPLOYEE SOCIAL SECURITY NUMBER

OR 1 ____
OR 2 ____
OR 3 ____
OR 4 ____
OR 5 ____
OR 6 ____

8. EMPLOYEE HOME ADDRESS

CITY, STATE ZIP

ZIP CODE

9. EMPLOYER (COMPANY) NAME AND ADDRESS

New Paltz United Teachers Benefit Trust Fund

10. GROUP NUMBER

1417

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

	NO	YES	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
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:

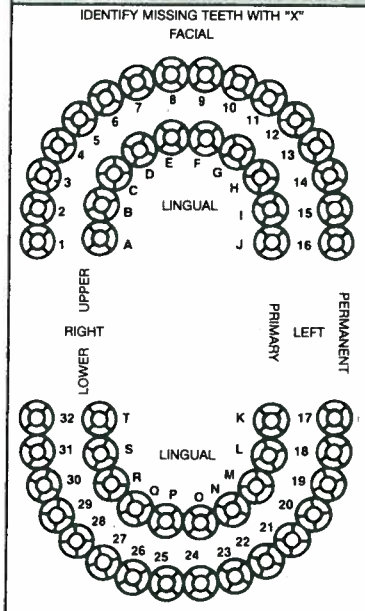
DATE APPLIANCES PLACED

MONTHS TREATMENT REMAINING

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?

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