DELTA DENTAL

CLAIM FORM

FOR DDPK USE ONLY

ATTENDING DENTIST'S STATEMENT

CHECK ONE: ☐ FOR PREDETERMINATION
☐ FOR PAYMENT

P.O. Box 789769
Wichita, KS 67278

PATIENT SECTION

1. PATIENT NAME — FIRST MIDDLE LAST
2. RELATIONSHIP TO EMPLOYEE — ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER
3. SEX — M F
4. PATIENT BIRTHDATE — MM DD YY
5. IF FULL TIME STUDENT OVER AGE 19 — SCHOOL CITY
6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS
7. EMPLOYEE/SUBSCRIBER SOC. SEC. NUMBER
8. EMPLOYEE/SUBSCRIBER BIRTHDATE — MM DD YY
9. EMPLOYER (COMPANY)
10. GROUP NUMBER
12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN (IF YES, COMPLETE 13-15.) — ☐ YES ☐ NO
IS PATIENT COVERED BY A MEDICAL PLAN? ☐ YES ☐ NO
13A. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)
13B. EMPLOYEE/SUBSCRIBER SOC. SEC. NUMBER
13C. EMPLOYEE/SUBSCRIBER BIRTHDAY — MM DD YY
13.D. RELATIONSHIP TO PATIENT — ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER
14. NAME AND ADDRESS OF EMPLOYER
15A. NAME AND ADDRESS OF CARRIER(S)
15B. GROUP NO.(S)
15C. AMOUNT PAID BY OTHER INSURANCE

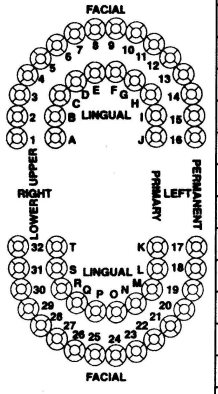
I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT THE PORTION OF THE DENTIST'S CHARGES COVERED UNDER THE DENTAL CARE PLAN NAMED ABOVE WILL BE PAID DIRECTLY TO THE DENTIST, UNLESS THE DENTIST IS NOT A PARTICIPATING DENTIST WITH DELTA DENTAL OF KANSAS IN WHICH CASE PAYMENT WILL BE MADE DIRECTLY TO THE SUBSCRIBER.

PATIENT (PARENT OR EMPLOYEE) SIGNATURE X _____ DATE _____

DENTIST SECTION

16. DENTIST NAME OR BUSINESS NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. DENTIST SOC. SEC. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT — OFFICE ☐ HOSP. ☐ ECF ☐ OTHER ☐
23. X-RAYS, PHOTOS, MODELS ENCLOSED? — NO ☐ YES ☐ HOW MANY?
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? — NO ☐ YES ☐ IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT? — NO ☐ YES ☐
26. OTHER ACCIDENT? — NO ☐ YES ☐
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? — NO ☐ YES ☐ (IF NO, REASON FOR REPLACEMENT)
29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS? — NO ☐ YES ☐ IF SERVICES ALREADY COMMENCED ENTER — DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



38. REMARKS FOR UNUSUAL SERVICES

32. TOOTH # OR LETTER	33. ARCH SURFACE OR QUAD.	34. DESCRIPTION OF SERVICE	35. DATE SERVICE COMPLETED MO. DAY YEAR	36. PROC. CODE	37. FEE	32. TOOTH # OR LETTER	33. ARCH SURFACE OR QUAD.	34. DESCRIPTION OF SERVICE	35. DATE SERVICE COMPLETED MO. DAY YEAR	36. PROC. CODE	37. FEE
		Periodic Oral Evaluation		0120				Composite - Resin		23__	
		Ltd. Oral Eval.-Problem Focused		0140				Composite - Resin		23__	
		Comprehensive Oral Evaluation		0150				Composite - Resin		23__	
		Detailed Oral Eval.-Problem Focused		0160							
								R.C.T. Anterior		3310	
		F.M. X-Ray		0210				R.C.T. Bicuspid		3320	
		1st P.A. X-Ray		0220				R.C.T. Molar		3330	
		( ) Add'l P.A. X-Ray		0230							
								Root Planning/Scaling		4341	
								Root Planning/Scaling		4341	
		Bitewing - Two Films		0272				Perio Maintenance		4910	
		Bitewing - Four Films		0274							
								Extraction		7140	
		Panoramic - Max. and Man.		0330				Extraction		7140	
		Adult Prophy		1110							
		Child Prophy (through age 13)		1120							
		Fluoride - Child (excluding prophy)		1203							
		Amalgam		21__							
		Amalgam		21__							
		Amalgam		21__							

39. I HEREBY CERTIFY THAT THE PROCEDURES, AS INDICATED BY DATE, HAVE BEEN COMPLETED BY ME AND WERE NECESSARY IN MY PROFESSIONAL JUDGMENT AND THAT THE FEE SHOWN IS MY USUAL FEE AND THE FEE I INTEND TO COLLECT EXCEPT WHERE NOTED. I REQUEST PAYMENT IN ACCORDANCE WITH DDPK RULES AND REGULATIONS.

X _____ SIGNED (TREATING DENTIST) _____ LICENSE NUMBER _____ DATE

TOTAL FEE CHARGED

DD-2005 Rev. 6/02