

- PLEASE TYPE OR PRINT
- DO NOT USE A HIGHLIGHTER
- STAPLE X-RAYS TO TOP RIGHT CORNER
- SEND PAGE 1 TO DELTA

DELTA DENTAL OF CALIFORNIA ENCOURAGES DENTAL OFFICES TO SUBMIT CLAIMS ELECTRONICALLY.



P.O. Box 997330
 Sacramento, CA 95899-7330
 Customer Service 800-846-7418

DELTA DENTAL USE ONLY

Delta Dental PPO

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YEAR		5. IF FULL TIME STUDENT AND OVER AGE 18, INDICATE: SCHOOL CITY	
6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST		7. MEMBER ID NUMBER		8. EMPLOYEE BIRTHDATE MO. DAY YEAR		9. EMPLOYER (COMPANY) NAME AND ADDRESS/ UNION LOCAL Screen Actors Guild —		10. GROUP NUMBER 8469	
EMPLOYEE MAILING ADDRESS		APT. NO.		PHONE NO.		Producers Health Plan			
CITY, STATE, ZIP		ZIP CODE							
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES NO		12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.		12b. GROUP NUMBER		13. NAME AND ADDRESS OF EMPLOYER, ITEM 11			
14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)		14b. MEMBER ID NUMBER		14c. EMPLOYEE BIRTHDATE MO. DAY YEAR		15. RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER			
16. DENTIST NAME		LICENSE NUMBER		24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO		YES	
17. MAILING ADDRESS		PHONE NO.		25. IS TREATMENT RESULT OF AUTO ACCIDENT?		NO		YES	
CITY, STATE, ZIP		ZIP CODE		26. OTHER ACCIDENT?		NO		YES	
18. DENTIST SOC. SEC. NO. OR T.I.N.		19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.		29. DATE OF PRIOR PLACEMENT	
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		30. IS TREATMENT FOR ORTHODONTICS? NO YES		IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

IDENTIFY MISSING TEETH WITH "X"		31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32, USE CHARTING SYSTEM SHOWN.							
		TOOTH NO. OR LETTER	SUR-FACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y			PROCEDURE NUMBER	FEE
		1							
		2							
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		13							
		14							
15									
32. REMARKS FOR UNUSUAL SERVICES OR AMOUNT PAID BY OTHER COVERAGE									

MY DENTIST MAY GIVE DELTA DENTAL AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE. SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____ DATE _____ <i>You may receive a copy of this authorization on request.</i>		TOTAL FEE CHARGED	
		PATIENT PAYS	
		PLAN PAYS	
PREDETERMINATION OF COST THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST A PREDETERMINATION OF COST. DENTIST SIGNATURE _____ DATE _____		TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM. DENTIST SIGNATURE _____ DATE _____	
		AMOUNT APPLIED TO DEDUCTIBLE	

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.