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

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

DELTA DENTAL®

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

DELTA DENTAL USE ONLY

Delta Dental PPO

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

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: **SAG-AFTRA Health Plan**
10. GROUP NUMBER: **8469**

EMPLOYEE MAILING ADDRESS — APT. NO. — PHONE NO.
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**
17. MAILING ADDRESS — PHONE NO.
CITY, STATE, ZIP — **ZIP CODE**

	NO	YES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	☐	☐
25. IS TREATMENT RESULT OF AUTO ACCIDENT?	☐	☐
26. OTHER ACCIDENT?	☐	☐
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?	☐	☐

IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.

18. DENTIST SOC. SEC. NO. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.

	NO	YES
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.	☐	☐

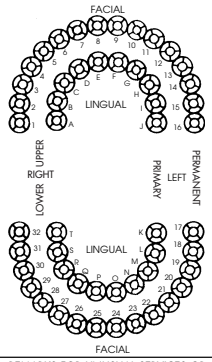
29. DATE OF PRIOR PLACEMENT

21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT: OFFICE ☐ HOSP. ☐ ECF ☐ OTHER ☐
23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?

	NO	YES
30. IS TREATMENT FOR ORTHODONTICS?	☐	☐

IF SERVICES ALREADY COMMENCED, ENTER → DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

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	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y		PROCEDURE NUMBER	FEE	
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		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 _____

You may receive a copy of this authorization on request.

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

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 _____

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

1. SUBMIT PAGE 1 TO DELTA DENTAL.
2. RETAIN PAGE 2 FOR YOUR FILES.

ATTENDING DENTIST'S STATEMENT
DELTA 105 Rev. 4/05