

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION																													
1. <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES <input type="checkbox"/> PRE-TREATMENT ESTIMATE																													
<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 5px; margin-right: 10px;"> MAIL CLAIMS TO </div> <div style="text-align: left;"> DELTA DENTAL P.O. BOX 9085 FARMINGTON HILLS, MI 48333-9085 </div> </div>																													
OTHER COVERAGE																													
2. OTHER DENTAL OR MEDICAL COVERAGE? <input type="checkbox"/> NO IF NO, SKIP TO #11 <input type="checkbox"/> YES						3. AMOUNT OF PRIMARY PAYMENT \$																							
4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																													
SUBSCRIBER INFORMATION																													
11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																													
12. DATE OF BIRTH				13. GENDER <input type="checkbox"/> M <input type="checkbox"/> F				14. SUBSCRIBER ID (SSN OR ID#)																					
15. PLAN/GROUP NUMBER						16. EMPLOYER NAME																							
PATIENT INFORMATION																													
5. DATE OF BIRTH			6. GENDER <input type="checkbox"/> M <input type="checkbox"/> F			7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)																							
17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)				18. RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER				19. DATE OF BIRTH		20. GENDER <input type="checkbox"/> M <input type="checkbox"/> F																			
8. PLAN/GROUP NUMBER				9. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER				21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> TOTALLY & PERM DISABLED <input type="checkbox"/> IRS DEPENDENT <input type="checkbox"/> SPONSORED DEPENDENT																					
10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME																													
DENTAL SERVICES																													
	22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION					28. FEE																		
1																													
2																													
3																													
4																													
5																													
6																													
7																													
8																													
9																													
10																													
MISSING TEETH		PERMANENT										PRIMARY										29. TOTAL FEE CHARGED							
30. PLACE X ON MISSING TOOTH NUMBERS		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	K
		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			
REMARKS																													
31.																													
AUTHORIZATIONS															ADDITIONAL CLAIM INFORMATION														
32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM. _____ PATIENT/GUARDIAN SIGNATURE DATE															34. PLACE OF TREATMENT <input type="checkbox"/> DENTAL OFFICE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ECF <input type="checkbox"/> OTHER														
33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST. _____ SUBSCRIBER SIGNATURE DATE															35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____														
															36. IS TREATMENT RELATED TO ORTHODONTICS? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____														
															37. TREATMENT RESULTING FROM: <input type="checkbox"/> OCCUPATIONAL ILLNESS/INJURY <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER ACCIDENT														
															38. REPLACEMENT OF PROSTHESIS? <input type="checkbox"/> YES DATE PRIOR PLACEMENT _____ <input type="checkbox"/> NO														
BILLING DENTIST/DENTAL ENTITY <small>(#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)</small>															TREATING DENTIST AND LOCATION														
39. NAME, ADDRESS, CITY, STATE, ZIP															44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT. X _____ SIGNED (TREATING DENTIST) DATE														
40. NPI					41. LICENSE NUMBER					42. TIN					45. NPI					46. LICENSE NUMBER					47. TIN				
43. PHONE NUMBER ()															48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)														
49. PHONE NUMBER ()															50. ADDITIONAL DENTIST ID					51. SPECIALTY CODE									

For the fastest processing, submit claims electronically through our **Dental Office Toolkit!**
It's free, easy, and available to all dentists. Check our Web sites for more information.

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- Clearly type, hand write, or use a computer printer to enter information.
- Use all upper-case (capital) letters, if possible.
- Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.
- Keep information within the correct field.
- Make sure the typewriter or printer ribbon is dark and the print can be easily read.
- Cover mistakes with line tape and print or type over—do not use liquid correction fluid.
- Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter \$0 unless the primary carrier's determination of payment was \$0. DO NOT ATTACH the primary carrier's voucher.
- Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- Hand or machine print
- When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).
- Use current ADA CDT procedure codes.
- Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.

FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.
- Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.
- Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS TO:	MAIL INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085	Delta Dental Attn: Customer Service P.O. Box 9089 Farmington Hills, MI 48333-9089	(800) 524-0149

Delta Dental of Michigan
www.deltadentalmi.com

Delta Dental of Ohio
www.deltadentaloh.com

Delta Dental of Indiana
www.deltadentalin.com

Delta Dental of North Carolina
www.deltadentalnc.com

FRAUD WARNINGS

Please read the warning statement for the state where you reside and for the state where your policy was issued.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance {Footnote 1} is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in R.S.A. 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 \$5000 and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: No person shall, with intent to defraud, present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact. Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.