DELTA DENTAL®

Delta Dental Plan of Virginia

4818 Starkey Road
Roanoke, VA 24014

(540) 989-8000 or (1-800) 237-6060

❒ **Claim For Payment**

❒ **Claim For Predetermination**

EMPLOYEE/SUBSCRIBER MUST COMPLETE SECTIONS 1-17

1. PATIENT NAME	2. RELATIONSHIP TO SUBSCRIBER: SELF / SPOUSE / CHILD / OTHER	3. SEX: M / F	4. PATIENT BIRTHDATE: MO. / DAY / YEAR	5. IF PATIENT IS CHILD AGE 19 OR OVER, FULL TIME STUDENT: NO ☐ YES ☐ NAME OF SCHOOL

6. SUBSCRIBER	FIRST	MIDDLE	LAST	7. SUBSCRIBER SOCIAL SECURITY NO	8. NAME OF EMPLOYER

10. SUBSCRIBER MAILING ADDRESS		9. GROUP NUMBER
11. CITY STATE, ZIP		

12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO ☐ YES ☐ IF YES: Þ	13. EMPLOYEE NAME AND BIRTHDATE	14. SOCIAL SEC. NO.	15. EMPLOYER NAME
	16. NAME AND ADDRESS OF CARRIER		17. GROUP NO.

NAME OF DENTIST OR DENTAL ENTITY		TAX ID OR SOC. SEC. NO.	IS TREATMENT RESULT OF ACCIDENT? NO ❒ YES ❒ IF YES, DATE IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY NO ❒ YES ❒
MAILING ADDRESS		LICENSE NO.	RADIOGRAPHS OR MODELS ENCLOSED? NO ❒ YES ❒ HOW MANY? IF PROSTHESIS: IS THIS INITIAL PLACEMENT? NO ❒ YES ❒ IF NO, ENTER REASON FOR REPLACEMENT AND DATE OF PLACEMENT IN REMARKS BELOW
CITY STATE, ZIP		TELEPHONE NO.	IS TREATMENT FOR ORTHODONTICS? NO ❒ YES ❒ IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCE PLACED: MOS TREATMENT REMAINING:

DESCRIPTION	TOOTH	SURFACE	DATE	ADA CODE	FEE	DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE
Initial Exam				0110							
Recall Exam				0120							
FM X-Rays (BW)				0210							
1st PA X-Ray				0220							
( ) Add PA				0230							
2-BW-X-Ray				0272							
4-BW-X-Ray				0274							
Panelipse				0330							
Adult Prophy				1110							
Child Prophy				1120							
Fluoride				1203							
Amal Dec 1SF				2110							
Amal Dec 1SF				2110							
Amal Dec 1SF				2110							
Amal Dec 2SF				2120							
Amal Dec 2SF				2120							
Amal Dec 3SF				2130							
Amal Dec 3SF				2130							
Amal Perm 1SF				2140							
Amal Perm 1SF				2140							
Amal Perm 1SF				2140							
Amal Perm 2SF				2150							
Amal Perm 2SF				2150							
Amal Perm 3SF				2160							
Amal Perm 3SF				2160							
Amal Perm 4SF				2161							
Comp 1SF				2330							
Comp 1SF				2330							
Comp 1SF				2330							
Comp 2SF				2331							
Comp 3SF				2332							
Pulpotomy				3220							
RCT-Ant				3310							
RCT-Bicsp				3320							
RCT-Molar				3330							
1st Ext				7110							
Add Ext				7120							
Add Ext				7120							

TOTAL FEE CHARGED

ANY SERVICE EXCEEDING $250.00 SHOULD BE PRE-DETERMINED

CLAIM SHOULD BE FILED WITHIN SIX MONTHS OF DATE OF SERVICE

REMARKS FOR UNUSUAL SERVICES

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO.
I CERTIFY THE TRUTH OF PERSONAL INFORMATION CONTAINED ABOVE.
I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.

PATIENT (PARENT OR EMPLOYEE) SIGNATURE **x** DATE

(TREATMENT COMPLETED-PAYMENT REQUESTED)

THE TREATMENT LISTED WAS COMPLETED AND WAS NECESSARY IN MY PROFESSIONAL JUDGEMENT. I REQUEST PAYMENT IN ACCORDANCE WITH DDPV PARTICIPATING DENTIST RULES.

DENTIST SIGNATURE **x** **DATE**

(PREDETERMINATION OF COST)

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST AUTHORIZATION IN ACCORDANCE WITH DDPV PARTICIPATING DENTIST RULES.

DENTIST SIGNATURE **x** **DATE**