

SIGN BELOW
FOR PREDETERMINATION *
OR PAYMENT **

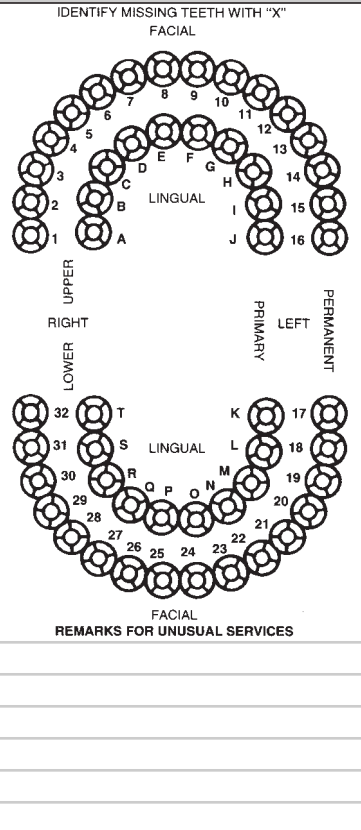
One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME LAST FIRST MIDDLE INT.		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YEAR		5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL CITY	
6. EMPLOYEE/SUBSCRIBER NAME		7. EMPLOYEE SOCIAL SECURITY NUMBER		8. EMPLOYEE HOME ADDRESS CITY, STATE ZIP		9. EMPLOYER (COMPANY) NAME AND ADDRESS ZIP CODE		OR 1 _____ OR 2 _____ OR 3 _____ OR 4 _____ OR 5 _____ OR 6 _____	
10. GROUP NUMBER		11. DELTA - COVERED EMPLOYEE BIRTH DATE MO. DAY YEAR		12. SPOUSE NAME		13. SPOUSE BIRTHDATE MO. DAY YEAR		14. NAME AND ADDRESS OF CARRIER	
15. SPOUSE SOCIAL SECURITY NUMBER									

DENTIST NAME		IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO YES		IF YES, ENTER BRIEF DESCRIPTION AND DATES	
MAILING ADDRESS		IS TREATMENT RESULT OF AUTO ACCIDENT?		NO YES			
CITY, STATE ZIP		OTHER ACCIDENT?		NO YES			
DENTIST SOC. SEC. NO. OR FED. IDENT. NO.		DENTIST LICENSE		DENTIST PHONE NO.		IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
FIRST VISIT DATE CURRENT SERIES		PLACE OF TREATMENT OFFICE OTHER		RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		DATE OF PRIOR PLACEMENT	
						IS TREATMENT FOR ORTHODONTICS? NO YES	
						IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING	



EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.							
TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED			ADA PROCEDURE NUMBER	FEE
			MO.	DAY	YR.		
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<p>* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS.</p>		<p>I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.</p>	TOTAL FEE CHARGED	
<p>DENTIST SIGNATURE _____ DATE _____</p>			PATIENT PAYS	
<p>** TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.</p>		PATIENT SIGNATURE _____	DELTA PAYS	
<p>DENTIST SIGNATURE _____ DATE _____</p>		DATE _____	AMOUNT APPLIED TO DEDUCTIBLE	