Delta Dental of New York, Inc.
P.O. Box 2105
Mechanicsburg, PA 17055-2105
(717) 766-8500 (800) 932-0783
TTY/TDD 888-373-3582
www.deltadentalins.com

ATTENDING DENTIST'S STATEMENT

SIGN BELOW FOR PREDETERMINATION * OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER
3. SEX: M | F
IMPORTANT — 4. PATIENT BIRTHDATE: MO. | DAY | YR.
5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE: SCHOOL | CITY

6. EMPLOYEE/ SUBSCRIBER NAME: LAST | FIRST | MIDDLE INITIAL
IMPORTANT — 7. SUBSCRIBER I.D. NUMBER

OR 1 ____
OR 2 ____
OR 3 ____
OR 4 ____
OR 5 ____
OR 6 ____

8. EMPLOYEE HOME ADDRESS
CITY, STATE ZIP — ZIP CODE
9. EMPLOYER (COMPANY) NAME AND ADDRESS

10. GROUP NUMBER: NY 2443
IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15
11. DELTA - COVERED EMPLOYEE BIRTHDATE: MO. | DAY | YR.
12. SPOUSE NAME
13. SPOUSE BIRTHDATE: MO. | DAY | YR.
14. NAME AND ADDRESS OF CARRIER
15. SPOUSE I.D. NUMBER

DENTIST NAME
MAILING ADDRESS
CITY, STATE ZIP

IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO | YES — IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT?
OTHER ACCIDENT?
IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO | YES — IF NO, ENTER REASON FOR REPLACEMENT
DATE OF PRIOR PLACEMENT
IS TREATMENT FOR ORTHODONTICS? NO | YES
IF SERVICES ALREADY COMMENCED, ENTER:
DATE APPLIANCES PLACED
MONTHS TREATMENT REMAINING

DENTIST I.D. NUMBER (NPI) | DENTIST LICENSE | DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT: OFFICE | OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY?

IDENTIFY MISSING TEETH WITH "X"

FACIAL
UPPER — RIGHT — LINGUAL — LEFT — PRIMARY — PERMANENT
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
LOWER — LINGUAL
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 K
FACIAL

REMARKS FOR UNUSUAL SERVICES

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 Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO.	DAY	YR.	ADA PROCEDURE NUMBER	FEE
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					
		16					
		17					
		18					
		19					
		20					

Pursuant to law, please be advised that 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 five thousand dollars and the stated value of the claim for each such violation.

* PREDETERMINATION OF COSTS
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS

DENTIST SIGNATURE | DATE

** TREATMENT COMPLETED – PAYMENT REQUESTED
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.

DENTIST SIGNATURE | DATE

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.

PATIENT SIGNATURE ____________

DATE ____________

TOTAL FEE CHARGED	
PATIENT PAYS	
DELTA PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

FORM DD/NY-0016-04-10