DELTA DENTAL®

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – **OR** – ☐ Request for Predetermination/Preauthorization

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

4. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

5. Date of Birth (MM/DD/CCYY) | 6. Gender ☐ M ☐ F | 7. Subscriber Identifier (SSN or ID#)

8. Plan/Group Number | 9. Employer Name

PATIENT INFORMATION

10. Relationship to Primary Subscriber (Check applicable box)
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

11. Student Status ☐ FTS ☐ PTS

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Patient ID/Account # (Assigned by Dentist)

CARRIER NAME AND ADDRESS:

2. Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532
(Please do not use for DeltaCare dental HMO)

OTHER COVERAGE

16. Other Dental or Medical Coverage? ☐ No (Skip 17-23) ☐ Yes (Complete 16-23)

17. Subscriber Name (Last, First, Middle Initial, Suffix)

18. Date of Birth (MM/DD/CCYY) | 19. Gender ☐ M ☐ F | 20. Subscriber Identifier (SSN or ID#)

21. Plan/Group Number | 22. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

23. Other Carrier Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	30. Description	31. Fee
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

MISSING TEETH INFORMATION

33. (Place an 'X' on each missing tooth)

Permanent																Primary									
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
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

31a. Other Fee(s)

32. Total Fee

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prostheses? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Corporate Entity NPI (Type 2) | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) Date

54. Individual NPI (Type 1) | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

Discrimination is Against the Law

Delta Dental of Illinois complies with all applicable Federal and State civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender, or gender identity. Delta Dental of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, gender or gender identity.

Delta Dental of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator: Stacey Bonn

If you believe that Delta Dental of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender, or gender identity, you can file a grievance with:

Director of Client Services
Delta Dental of Illinois
111 Shuman Boulevard
Naperville IL 60563
Phone: 800-323-1743
Email: csi@deltadentalil.com

You can file a grievance in person or by mail, phone or email. If you need help filing a grievance, our Director of Client Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://hhs.gov/ocr/office/file/index.html

If you or someone you are helping has questions about Delta Dental of Illinois, you have the right to get help and information in your language at no cost.

Arabic
ةالـ عربـ ي
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. .1-800-323-1743
Chinese
繁體中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-323-1743。
French
Français
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-323-1743.
German
Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-323-1743.
Greek
Ελληνικά
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-323-1743.
Gujarati
ગુજરાતી
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-323-1743.
Hindi
हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-323-1743 पर कॉल करें।
Italian
Italiano
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-323-1743.
Korean
한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-323-1743 번으로 전화해 주십시오.
Polski
Polski
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-323-1743.
Russian
Русский
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-323-1743.
Spanish
Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-323-1743.
Tagalog
Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-323-1743.
Urdu
وارد
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-800-323-1743. کریں
Vietnamese
Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-323-1743.