1. PLEASE TYPE OR PRINT
2. DO NOT USE A HIGHLIGHTER
3. STAPLE X-RAYS TO TOP RIGHT CORNER
4. SEND PAGE 1 TO DELTA

DELTA DENTAL PLAN OF CALIFORNIA ENCOURAGES DENTAL OFFICES TO SUBMIT CLAIMS ELECTRONICALLY.

M109691 (4/00)

DELTA DENTAL® Delta Dental Plan of California

P.O. Box 7736
San Francisco, California 94120-7736
(888) 335-8227

DELTA USE ONLY

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME | 2. RELATIONSHIP TO EMPLOYEE: SELF SPOUSE CHILD OTHER | 3. SEX: M F | 4. PATIENT BIRTHDATE: MO. DAY YEAR | 5. IF FULL TIME STUDENT AND OVER AGE 18, INDICATE: SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME: FIRST MIDDLE LAST | **7. EMPLOYEE SOCIAL SECURITY NUMBER** | 8. EMPLOYEE BIRTHDATE: MO. DAY YEAR | 9. EMPLOYER (COMPANY) NAME AND ADDRESS/ UNION LOCAL | 10. GROUP NUMBER

EMPLOYEE MAILING ADDRESS — APT. NO. — PHONE NO.

CITY, STATE, ZIP — **ZIP CODE**

11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES _____ NO _____ | 12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11. | 12b. GROUP NUMBER | 13. NAME AND ADDRESS OF EMPLOYER, ITEM 11

14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S) | 14b. EMPLOYEE SOCIAL SECURITY NUMBER | 14c. EMPLOYEE BIRTHDATE: MO. DAY YEAR | 15. RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

16. DENTIST NAME — **LICENSE NUMBER**

17. MAILING ADDRESS — PHONE NO.

CITY, STATE, ZIP — **ZIP CODE**

	NO	YES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		
25. IS TREATMENT RESULT OF AUTO ACCIDENT?		
26. OTHER ACCIDENT?		
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?		

IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.

18. DENTIST SOC. SEC. NO. OR T.I.N. | 19. DENTIST LICENSE NO. | 20. DENTIST PHONE NO.

	NO	YES
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.		

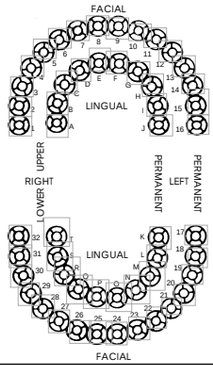
29. DATE OF PRIOR PLACEMENT

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT: OFFICE HOSP. ECF OTHER | 23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY?

	NO	YES
30. IS TREATMENT FOR ORTHODONTICS?		

IF SERVICES ALREADY COMMENCED, ENTER → DATE APPLIANCES PLACED | MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32, USE CHARTING SYSTEM SHOWN.

TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y		PROCEDURE NUMBER	FEE	
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

32. REMARKS FOR UNUSUAL SERVICES OR **AMOUNT PAID BY OTHER COVERAGE**

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE.

SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____ DATE _____

You may receive a copy of this authorization on request.

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST A PREDETERMINATION OF COST.

DENTIST SIGNATURE _____ DATE _____

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM.

DENTIST SIGNATURE _____ DATE _____

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

1. SUBMIT PAGE 1 TO DELTA.
2. RETAIN PAGE 2 FOR YOUR FILES.

ATTENDING DENTIST'S STATEMENT
DELTA 105 Rev. 4/00

RECYCLEABLE