

Delta Dental of the District of Columbia

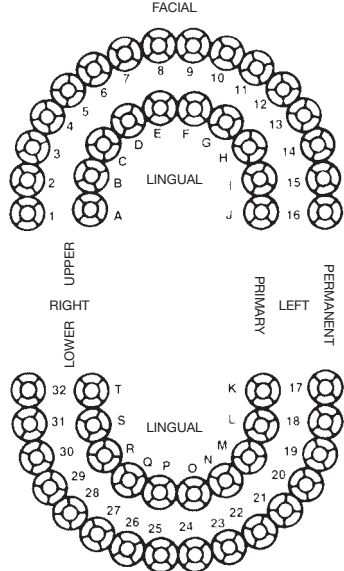
 One Delta Drive  
 Mechanicsburg, PA 17055-6999  
 (717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

 SIGN BELOW  
 FOR PREDETERMINATION \*  
 OR PAYMENT \*\*

**STAPLE X-RAYS TO FORM**

<b>EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15</b>	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			OR 1 _____ OR 2 _____ OR 3 _____ OR 4 _____ OR 5 _____ OR 6 _____	
8. EMPLOYEE HOME ADDRESS  CITY, STATE ZIP	9. EMPLOYER (COMPANY) NAME AND ADDRESS  ZIP CODE				
10. GROUP NUMBER	IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15	11. DELTA - COVERED EMPLOYEE BIRTHDATE 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  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? NO YES OTHER ACCIDENT?
DENTIST SOC. SEC. NO. OR FED. IDENT. NO. DENTIST LICENSE DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO YES IF NO, ENTER REASON FOR REPLACEMENT
FIRST VISIT DATE CURRENT SERIES PLACE OF TREATMENT OFFICE OTHER RADIOGRAPHS OR MODELS ENCLOSED? HOW MANY?	DATE OF PRIOR PLACEMENT IS TREATMENT FOR ORTHODONTICS? NO YES IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X" FACIAL  LINGUAL UPPER RIGHT PERMANENT LEFT LOWER PRIMARY FACIAL REMARKS FOR UNUSUAL SERVICES	<b>EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.</b> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>TOOTH # OR LETTER</th> <th>SURFACES MOI DLF</th> <th>Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc.</th> <th>DATE SERVICE PERFORMED MO. DAY YR.</th> <th>ADA PROCEDURE NUMBER</th> <th>FEE</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>9</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>11</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>12</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>13</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>14</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>15</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>16</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>17</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>18</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>19</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>20</td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table> <p>Pursuant to law, please be advised that it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.</p>	TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Service 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					
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* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS	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.	TOTAL FEE CHARGED	PATIENT PAYS
DENTIST SIGNATURE DATE	PATIENT SIGNATURE	DELTA PAYS	AMOUNT APPLIED TO DEDUCTIBLE
** 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.	DATE		

FORM DD/DC-0016-98-06