DELTA DENTAL®

HEADER INFORMATION

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

CARRIER NAME AND ADDRESS:

2. Northeast Delta Dental (Maine, New Hampshire & Vermont)
P.O. Box 2002
Concord, NH 03302-2002
Payer ID 02027

PRIMARY PAYER INFORMATION

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

OTHER COVERAGE

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

PRIMARY SUBSCRIBER INFORMATION

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

5. Date of Birth (MM/DD/CCYY) | 6. Gender | 7. Subscriber Identifier (ID#)

8. Plan/Group Number | 9. Employer Name

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

18. Date of Birth (MM/DD/CCYY) | 19. Gender | 20. Subscriber Identifier (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

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 | 15. Patient ID/Account # (Assigned by Dentist)

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. Date Last SRP _____/_____/_____

41. Is Treatment for Orthodontics? ☐ No (Skip 42-43) ☐ Yes (Complete 42-43)

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

43. Months of Treatment Remaining

44. Replacement of Prostheses? ☐ No ☐ Yes (Complete 45)

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

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

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

48. 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)

49. Name, Address, City, State, ZIP Code

50. Corporate Entity NPI (Type 2) | 51. License Number | 52. TIN

53. Phone Number ( ) - | 53a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. 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

55. Individual NPI (Type 1) Locum Tenens Treating Dentist? | 56. License Number

57. Address, City, State, ZIP Code | 57a. Provider Specialty Code

58. Phone Number ( ) - | 59. Treating Provider Specialty