

Northeast Delta Dental One Delta Drive PO Box 2002 Concord, NH 03302-2002

Dependent Verification Request

То:		Group: Date: Subscriber ID:	
to ensure time	eipt of a claim for your dependent noted below. By processing of the claim, we would appreciate to respond within 21 days, we will assume the enied.	e your completing this form a	and promptly returning it. If
Dependent's Name:		Birth Date:	
	dependent a student in an accredited school	ol, college, or university?	Yes No
If yes:	Name of the School:		
	Current school year:	to	
	Is the dependent incapacitated? dependent is incapacitated, we must receive r letterhead, which must include the following.		he attending physician on
	A) Type of disabilityB) Prognosis – permanent or temporaryC) If temporarily disabled, expected duration		
reflect the dep	rn of this form to our office, the claim will be propendent's status as verified by you and/or the at year. Please remember to notify your employed	ttending physician. Students	will be updated for the
If you have an 800-832-5700	y questions, please feel free to contact our Cus	stomer Service department a	t 603-223-1234 or
I hereby affirm accurate.	n that, to the best of my knowledge and belief, t	he information provided in th	is document is true and
SUBSCRIBER	R'S SIGNATURE	Date	
Subscriber's d	aytime telephone number:		

This form is to be completed by the subscriber and returned to Northeast Delta Dental