

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services		2. Carrier Name and Address DELTA DENTAL PLAN OF ILLINOIS P.O. BOX 5402 LISLE, IL 60532										
3. Patient name first m.i. last		4. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____		5. Sex m f		6. Patient birthdate MM DD YYYY		7. If full time student school city				
8. Employee/subscriber name and mailing address			9. Employee/subscriber dental plan I.D. number				10. Employee/subscriber birthdate MM DD YYYY		11. Employer (company) name and address		12. Group number	
13. Is patient covered by another dental plan <input type="checkbox"/> yes <input type="checkbox"/> no If yes, complete 14a Is patient covered by a medical plan? <input type="checkbox"/> yes <input type="checkbox"/> no		14a. Name and address of other carrier(s)		14b. Other group no(s)		15. Name and address of other employer(s)						
16a. Employee/subscriber name (if different from patient's)				16b. Employee/subscriber birthdate MM DD YYYY		17. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____						
18. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless 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 under applicable law, I authorize release of any information relating to this claim. Signed (Parent or guardian) _____ Date _____						19. I hereby authorize payment directly to the above-name dentist of the group insurance benefits otherwise payable to me. Signed (Employee/subscriber) _____ Date _____						
20. Name of Billing Dentist or Dental Entity				29. Is treatment result of occupational illness or injury?		No Yes		If yes, enter brief description and dates				
21. Address				30. Is treatment result of auto accident?		No Yes		If yes, enter brief description and dates				
22. City, State, Zip				31. Other accident?		No Yes		If yes, enter brief description and dates				
23. Dentist Soc. Sec. or TIN		24. Dentist license no.		25. Dentist phone no.		32. If prosthesis, is this initial placement?		(If no, reason for replacement)		33. Date of prior placement		
26. First visit date current series	27. Place of treatment Office Hosp ECF Other		28. Radiographs or models enclosed?		No Yes	How many?	34. Is treatment for orthodontics?		No Yes	If service already commenced enter	Date appliances placed	Mos treatment remaining
35. Identify missing teeth with "X"		36. Examination and treatment plan - List in order from tooth no 1 through tooth no 32 - Using charting system shown.								For administrative use only		
		Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)			Date service performed Mo Day Year			Procedure number	Fee	
37. Remarks for unusual services												
38. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. Signed (Treating Dentist) _____ License Number _____ Date _____									40. Total Fee Charged		42. Payment by other plan	
39. Address where treatment was performed City _____ State _____ Zip _____									Max. Allowable		Deductible	
_____									Carrier %		Carrier pays	
_____									Patient pays		_____	