**ATTENDING DENTIST'S STATEMENT**

**FOR D.D. USE ONLY**

**DELTA DENTAL**

Delta Dental Plan of Arkansas
P.O. Box 15965
North Little Rock, Arkansas 72231-5965
(501) 835-3400 (800) 462-5410

**CHECK ONE:** ☐ FOR PREDETERMINATION ☐ FOR PAYMENT

## PATIENT SECTION

1. PATIENT NAME
2. RELATIONSHIP TO MEMBER — SELF ☐ SPOUSE ☐ DGHTR ☐ SON ☐ OTHER ☐ M ☐ F
3.
4. PATIENT BIRTHDATE — MO | DAY | YEAR
5. IF FULL TIME STUDENT — SCHOOL — CITY
6. EMPLOYEE/SUBSCRIBER NAME — FIRST MIDDLE LAST
7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS — TELEPHONE NUMBER
CITY, STATE, ZIP
9. NAME OF GROUP DENTAL PROGRAM
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. GROUP NUMBER
12. LOCATION (LOCAL)
13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME — SOCIAL SEC. NO. — BIRTHDATE
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? — DENTAL PLAN NAME — UNION LOCAL — GROUP NO. — NAME AND ADDRESS OF CARRIER

## DENTIST SECTION

16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. SOCIAL SECURITY NO.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? — NO | YES | HOW MANY?

**ATTACH X-RAYS SECURELY**

| | NO | YES | |
|---|---|---|---|
| 24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | | | IF YES, ENTER BRIEF DESCRIPTION AND DATES |
| 25. IS TREATMENT RESULT OF AUTO ACCIDENT? | | | |
| 26. OTHER ACCIDENT? | | | |
| 27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? | | | |
| 28. IF PROSTHESIS OR SINGLE CROWN(S), IS THIS INITIAL PLACEMENT? | | | (IF NO, REASON FOR REPLACEMENT) — 29. DATE OF PRIOR PLACEMENT |
| 30. IS TREATMENT FOR ORTHODONTICS? | | | IF SERVICES ALREADY COMMENCED, ENTER — DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING |

## DIAGNOSTIC

| DESCRIPTION | TOOTH # OR LETTER | SURFACE | DATE SERVICE PREFORMED MO. DAY YEAR | PROCEDURE NUMBER | FEE | DD USE | DESCRIPTION OF SERVICE | TOOTH # OR LETTER | SURFACE | DATE SERVICE PREFORMED MO. DAY YEAR | PROCEDURE NUMBER | FEE | DD USE |
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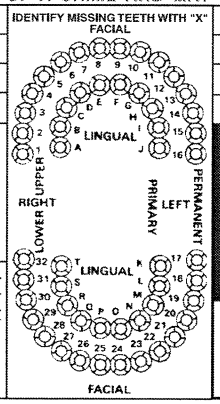
32. REMARKS FOR UNUSUAL SERVICES

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

IDENTIFY MISSING TEETH WITH "X"




I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE ABOVE HAVE BEEN PERFORMED ACCORDING TO THE PROVISIONS OF THE DENTAL CARE PLAN NAMED ABOVE. ALSO, THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THESE PROCEDURES. I AGREE TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE OF THIS FORM AND PAYMENT FOR SAID PROCEDURES IS NOW DUE.

DENTIST SIGNATURE X _____ DATE _____

OUT-STATE DENTIST: MEMBER OF LOCAL DELTA PLAN AND REQUESTING ASSIGNMENT OF BENEFITS. INITIAL: _____

I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT THE PORTION OF THE DENTIST'S CHARGES COVERED UNDER THE DENTAL CARE PLAN NAMED ABOVE WILL BE PAID DIRECT TO THE DENTIST UNLESS THE DENTIST IS NOT PARTICIPATING WITH A DELTA PLAN AND I AM PERSONALLY RESPONSIBLE FOR ANY PORTION OF THOSE CHARGES NOT COVERED BY THE PLAN.

PATIENT (PARENT OR MEMBER) SIGNATURE X _____ DATE _____

| | |
|---|---|
| TOT | |
| DELTA PAYS | |
| PAT PAYS | |

**MAIL ORIGINAL TO PLAN**
**RETAIN COPY FOR YOUR FILE.**