

- PLEASE TYPE OR PRINT
- DO NOT USE A HIGHLIGHTER
- STAPLE X-RAYS TO TOP RIGHT CORNER
- SEND PAGE 1 TO DELTA

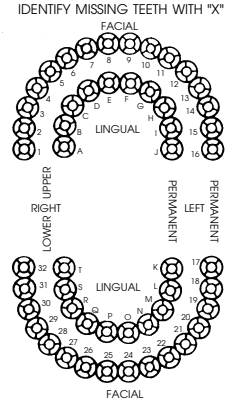
DELTA DENTAL OF CALIFORNIA ENCOURAGES DENTAL OFFICES TO SUBMIT CLAIMS ELECTRONICALLY.

DELTA DENTAL P.O. Box 997330
 Sacramento, CA 95899-7330
 Delta Dental of California Customer Service (888) 335-8227

DELTA USE ONLY

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME			2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F	4. PATIENT BIRTHDATE MO. DAY YEAR		5. IF FULL TIME STUDENT AND OVER AGE 18, INDICATE: SCHOOL CITY		
6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST			7. EMPLOYEE SOCIAL SECURITY NUMBER		8. EMPLOYEE BIRTHDATE MO. DAY YEAR		9. EMPLOYER (COMPANY) NAME AND ADDRESS/ UNION LOCAL		10. GROUP NUMBER	
EMPLOYEE MAILING ADDRESS APT. NO. PHONE NO. ZIP CODE										
CITY, STATE, ZIP										
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES NO		12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.			12b. GROUP NUMBER	13. NAME AND ADDRESS OF EMPLOYER, ITEM 11				
14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)			14b. EMPLOYEE SOCIAL SECURITY NUMBER		14c. EMPLOYEE BIRTHDATE MO. DAY YEAR		15. RELATIONSHIP TO PATIENT SELF SPOUSE PARENT OTHER			
16. DENTIST NAME		LICENSE NUMBER			24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.	
17. MAILING ADDRESS		PHONE NO. ZIP CODE			25. IS TREATMENT RESULT OF AUTO ACCIDENT?					
CITY, STATE, ZIP					26. OTHER ACCIDENT?					
					27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?					
18. DENTIST SOC. SEC. NO. OR T.I.N.		19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.		NO	YES	29. DATE OF PRIOR PLACEMENT
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES		30. IS TREATMENT FOR ORTHODONTICS?		NO	YES	IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X" 	31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32, USE CHARTING SYSTEM SHOWN.										
	TOOTH NO. OR LETTER	SUR-FACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y			PROCEDURE NUMBER	FEE			
	1										
	2										
	3										
	4										
	5										
	6										
	7										
	8										
	9										
	10										
	11										
	12										
	13										
14											
15											
32. REMARKS FOR UNUSUAL SERVICES OR											
AMOUNT PAID BY OTHER COVERAGE											

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE. SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____ DATE _____ <i>You may receive a copy of this authorization on request.</i>		TOTAL FEE CHARGED		
		PATIENT PAYS		
PREDETERMINATION OF COST THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST A PREDETERMINATION OF COST. DENTIST SIGNATURE _____ DATE _____		TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY. AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM. DENTIST SIGNATURE _____ DATE _____		PLAN PAYS
				AMOUNT APPLIED TO DEDUCTIBLE

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

- SUBMIT PAGE 1 TO DELTA.
- RETAIN PAGE 2 FOR YOUR FILES.