DELTA DENTAL®

Delta Dental of Wisconsin

Dental Plan Claim Form

POLICYHOLDER

Policyholder SSN/ID Number | Birth Date | Gender

Policyholder Name (Last, First, M.I., Suffix) | Policyholder Address

Policyholder City, State, Zip | Policyholder Employer | Plan/Group Number

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the named dentist or dental entity.

Signed: _____ Date: _____

PATIENT

Patient Name (Last, First, M.I., Suffix) | Gender

Relationship to Policyholder | Birth Date | ☐ Student

I have been informed of the treatment plan and associated fees. I agree to be responsible for 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.

Signed: _____ Date: _____

INSURANCE INFORMATION

Primary Insurance Company | Primary Insurance Address, City, State, Zip

Primary Insurance Payment

Transaction Type: ☐ Statement of Service ☐ Request for Predetermination/Preauthorization

Secondary Coverage: ☐ Yes ☐ No If Yes: ☐ Dental ☐ Medical

Name of Policyholder (Last, First, M.I., Suffix) _____

Relationship to Policyholder | Birth Date | Gender | Covered SSN/ID Number | Plan Group Number

Secondary Insurance Company | Secondary Insurance Address, City, State, Zip

Predetermination/Preauthorization Number

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The portion below should be filled out by the dentist who performed the service, or attach the Attending Dentist Statement.

ANCILLARY INFORMATION

Place of Treatment: ☐ Provider's Office ☐ Hospital

ECF Number of enclosures (0 to 99): Radiograph(s):____ Oral Image(s):____ Model(s):____ Charting:_____

Prosthesis Placed: ☐ Initial Placement ☐ Prior Placement Prior Placement Date: _____

Treatment resulting from: ☐ Occupational Injury/Illness ☐ Auto Accident

☐ Other Accident Accident Date: _____ Accident State: _____

Treatment for Orthodontics: ☐ Yes ☐ No Placed Date: _____ Months Remaining: _____

PROVIDER INFORMATION

I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

Provider Signature: _____ Date: _____

Treating Provider Name (Last, First, M.I., Suffix) | Phone | Treating Provider Address, City, State, Zip

Taxonomy Code | Provider NPI# (Type 1) | License #/Other ID | Provider Billing NPI# (Type 2) | License #/Other ID

Provider Billing Name (Last, First, M.I., Suffix) | Provider Billing SSN/TIN# | Phone

Provider Billing Address, City, State, Zip

SERVICES

Check Missing Tooth Number(s)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T												

Procedure Date	Oral Cavity	Tooth Letter	Tooth Surface	Diagnostic Codes	Procedure Code	Treatment	Fee
Remarks							Total Fee: