

<b>HEADER INFORMATION</b> 1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services – <b>OR</b> – <input type="checkbox"/> Request for Predetermination/Preauthorization					<b>CARRIER NAME AND ADDRESS:</b> 2. Delta Dental of Illinois P.O. Box 5402 Lisle, IL 60532 (Please do not use for DeltaCare dental HMO)																							
<b>PRIMARY PAYER INFORMATION</b> 3. Name, Address, City, State, Zip Code					<b>OTHER COVERAGE</b> 16. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 17-23) <input type="checkbox"/> Yes (Complete 16-23)																							
<b>PRIMARY SUBSCRIBER INFORMATION</b> 4. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code					17. Subscriber Name (Last, First, Middle Initial, Suffix)																							
5. Date of Birth (MM/DD/CCYY)		6. Gender <input type="checkbox"/> M <input type="checkbox"/> F		7. Subscriber Identifier (SSN or ID#)			18. Date of Birth (MM/DD/CCYY)		19. Gender <input type="checkbox"/> M <input type="checkbox"/> F		20. Subscriber Identifier (SSN or ID#)																	
8. Plan/Group Number		9. Employer Name			21. Plan/Group Number		22. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																					
<b>PATIENT INFORMATION</b> 10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other					11. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS		23. Other Carrier Name, Address, City, State, Zip Code																					
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code					13. Date of Birth (MM/DD/CCYY)		14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Patient ID/Account # (Assigned by Dentist)																			
<b>RECORD OF SERVICES PROVIDED</b>																												
1	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description				31. Fee																	
2																												
3																												
4																												
5																												
6																												
7																												
8																												
9																												
10																												
<b>MISSING TEETH INFORMATION</b>		Permanent										Primary										32. Other Fee(s)						
34. (Place an 'X' on each missing tooth)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33. Total Fee
35. Remarks		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	
<b>AUTHORIZATIONS</b> 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all 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.  X _____ Patient/Guardian signature Date					<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b> 38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other						39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)																	
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.  X _____ Subscriber signature Date					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)						41. Date Appliance Placed (MM/DD/CCYY)																	
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)					42. Months of Treatment Remaining						43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					44. Date Prior Placement (MM/DD/CCYY)												
48. Name, Address, City, State, Zip Code					45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident						46. Date of Accident (MM/DD/CCYY)					47. Auto Accident State												
49. Corporate Entity NPI (Type 2)					50. License Number					51. SSN or TIN					<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b> 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.  X _____ Signed (Treating Dentist) Date													
52. Phone Number ( ) -					54. Individual NPI (Type 1)						55. License Number					56. Address, City, State, Zip Code												
57. Phone Number ( ) -					58. Treating Provider Specialty						59. Address, City, State, Zip Code					60. Date of Service												