



Dental Plan Claim Form

Delta Dental of Michigan, Ohio, and Indiana

Policyholder

1. Policyholder SSN/ID#	2. Birth Date	3. Gender
4. Policyholder Name (Last, First, M.I., Suffix)		
5. Policyholder Address		
6. Policyholder City, State, Zip		
7. Policyholder Employer	8. Plan/Group #	
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

9. Patient Name (Last, First, M.I., Suffix)		10. Gender
11. Relationship to Policyholder	12. Birth Date	13. Student <input type="checkbox"/>
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: _____ Parent or Guardian		Date: - -

Insurance Information

14. Primary Insurance Company	
15. Primary Insurance Address, City, State, Zip	
16. Primary Insurance Payment	
17. Transaction Type: <input type="checkbox"/> Statement of Service <input type="checkbox"/> Request for Predetermination/Preauthorization	
Other Coverage	
18. Secondary Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Dental <input type="checkbox"/> Medical	
19. Name of Policyholder (Last, First, M.I., Suffix)	
20. Relationship to Policyholder	21. Birth Date
22. Gender	23. Covered SSN/ID#
24. Plan/Group #	25. Secondary Insurance Company
26. Predetermination/Preauthorization Number	
27. Secondary Insurance Address, City, State, Zip	

Ancillary Information

28. Place of Treatment (circle):		Provider's Office		Hospital		ECF	
29. Number of enclosures (0 to 99):		Radiograph(s):		Oral Image(s):		Model(s):	
Charting:		30. Prosthesis Placed: <input type="checkbox"/> Initial Placement <input type="checkbox"/> Prior Placement		31. Prior Placement Date - -			
32. Treatment resulting from: <input type="checkbox"/> Occupational Injury/Illness <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident		33. Accident Date - -		34. Accident State			
<input type="checkbox"/> 35. Treatment for Orthodontics		36. Placed Date - -		37. 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.			
Dentist Signature: _____		Date: - -	
38. Treating Provider Name (Last, First, M.I., Suffix)		39. Phone	
40. Treating Provider Address, City, State, Zip		41. Taxonomy Code	
42. Provider NPI# (Type 1)	43. License #/Other ID	44. Provider Billing NPI# (Type 2)	45. License #/Other ID
46. Provider Billing Name (Last, First, M.I., Suffix)		47. Provider Billing SSN/TIN#	48. Phone
49. Provider Billing Address, City, State, Zip			

Services

50. 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												
51. Procedure Date	52. Oral Cavity	53. Tooth #/Letter	54. Tooth Surface	55. Diagnostic Codes				56. Procedure Code	57. Treatment										58. Fee													
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59. Remarks														60. Total Fee																		