

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

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

DELTA USE ONLY

| | | | | | | | | | | | | | |
|--|--|--|--|---|---------------|--|--------------------------------------|----|---|---|--|------------------------|-----------------------------|
| 1. PATIENT NAME FIRST MIDDLE LAST | | | 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 | | | 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. | | | | | | | | |
| CITY, STATE, ZIP | | | ZIP CODE | | | | | | | | | | |
| 11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. | | | 12. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11. | | | 12. GROUP NUMBER | | | 13. NAME AND ADDRESS OF EMPLOYER, ITEM 11 | | | | |
| 14. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S) | | | 14. EMPLOYEE SOCIAL SECURITY NUMBER | | | 14. 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. | | | 25. IS TREATMENT RESULT OF AUTO ACCIDENT? | | | | | | | |
| CITY, STATE, ZIP | | | ZIP CODE | | | 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. | | | | 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 <input type="checkbox"/> YES <input type="checkbox"/> | | HOW MANY? | 30. IS TREATMENT FOR ORTHODONTICS? | | NO | YES | IF SERVICES ALREADY COMMENCED ENTER → | DATE APPLIANCES PLACED | MOS. TREATMENT REMAINING |
| | | | | | | | | | | | | | |