

STAPLE X-RAYS FOR ALL MAJOR SERVICES TO TOP LEFT CORNER OF FORMS. X-RAYS MUST BE LABELED WITH PATIENT NAME, DENTIST NAME AND ADDRESS.



P.O. Box 1809
 Alpharetta, GA 30023-1809
 NATIONWIDE (800) 521-2651
 LOCAL (770) 645-8700

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 SCHOOL CITY				
6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST		7. EMPLOYEE SOCIAL SECURITY NUMBER		7A. EMPLOYEE BIRTHDATE MO. DAY YEAR		9. NAME OF GROUP DENTAL PROGRAM					
8. EMPLOYEE MAILING ADDRESS CITY, STATE, ZIP				7B. SPOUSE BIRTHDATE MO. DAY YEAR		10. EMPLOYER (COMPANY) NAME AND ADDRESS					
11. EMPLOYEE GROUP NUMBER		12. LOCATION (LOCAL)		13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME SOC. SEC. NO.		14. NAME AND ADDRESS OF EMPLOYER, ITEM 13					
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?		DENTAL PLAN NAME		UNION LOCAL		GROUP NO.		NAME AND ADDRESS OF CARRIER			
16. DENTIST NAME				24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO YES		IF YES, ENTER BRIEF DESCRIPTION AND DATES			
17. MAILING ADDRESS CITY, STATE, ZIP		IS THIS ADDRESS NEW? YES <input type="checkbox"/> NO <input type="checkbox"/>		25. IS TREATMENT RESULT OF AUTO ACCIDENT?		NO YES					
				26. OTHER ACCIDENT?		NO YES					
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 MODEL ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		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 USING CHARTING SYSTEM SHOWN.							
				TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)		DATE SERVICE COMPLETED MO. DAY YEAR	PROCEDURE NUMBER	FEE	
32. REMARKS FOR UNUSUAL SERVICES											
I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY THE TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.				I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE BENEFITS OTHERWISE PAYABLE TO ME.				TOTAL FEE CHARGED			
PATIENT (PARENT OR EMPLOYEE) SIGNATURE X _____				X _____ EMPLOYEE SIGNATURE DATE				PATIENT PAYS			
NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.								PLAN PAYS			
PREDETERMINATION OF COST THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PREDETERMINATION OF BENEFITS.				TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED WAS COMPLETED ON DATES INDICATED AND WAS NECESSARY IN MY PROFESSIONAL JUDGMENT.				AMOUNT APPLIED TO DEDUCTIBLE			
DENTIST SIGNATURE DATE				DENTIST SIGNATURE DATE							

ATTENDING DENTIST'S STATEMENT

(SUBMIT TO DELTA) - WHITE
 (RETAIN FOR YOUR FILES) - YELLOW