Delta Dental of West Virginia
P.O. Box 2105
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783
TTY/TDD 888-373-3582
www.deltadentalins.com

ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION *
OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE — SELF / SPOUSE / CHILD / OTHER
3. SEX — M / F

IMPORTANT
4. PATIENT BIRTHDATE — MO. / DAY / YR.

5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE — SCHOOL / CITY

6. EMPLOYEE/ SUBSCRIBER NAME — LAST / FIRST / MIDDLE INITIAL

IMPORTANT
7. SUBSCRIBER I.D. NUMBER

OR 1 ______
OR 2 ______
OR 3 ______
OR 4 ______
OR 5 ______
OR 6 ______

8. EMPLOYEE HOME ADDRESS

CITY, STATE ZIP

ZIP CODE

9. EMPLOYER (COMPANY) NAME AND ADDRESS

10. GROUP NUMBER

IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15

11. DELTA - COVERED EMPLOYEE BIRTHDATE — MO. / DAY / YR.

12. SPOUSE NAME

13. SPOUSE BIRTHDATE — MO. / DAY / YR.

14. NAME AND ADDRESS OF CARRIER

15. SPOUSE I.D. NUMBER

DENTIST NAME

MAILING ADDRESS

CITY, STATE ZIP

	NO	YES	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, ENTER REASON FOR REPLACEMENT

DATE OF PRIOR PLACEMENT

	NO	YES
IS TREATMENT FOR ORTHODONTICS?		

IF SERVICES ALREADY COMMENCED, ENTER:

DATE APPLIANCES PLACED

MONTHS TREATMENT REMAINING

DENTIST I.D. NUMBER | DENTIST LICENSE | DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT — OFFICE / OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY?

IDENTIFY MISSING TEETH WITH "X"

FACIAL

7 8 9 10 11 12 13 14 15 16 6 5 4 3 2 1
E F G H I J D C B A

LINGUAL

UPPER

RIGHT

LOWER

PRIMARY

LEFT

PERMANENT

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

LINGUAL

FACIAL

REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO.	DAY	YR.	ADA PROCEDURE NUMBER	FEE
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					
		16					
		17					
		18					
		19					
		20					
		21					
		22					

* PREDETERMINATION OF COSTS
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS

DENTIST SIGNATURE DATE

** TREATMENT COMPLETED – PAYMENT REQUESTED
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.

DENTIST SIGNATURE DATE

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.

PATIENT SIGNATURE ______________________

DATE ______________________

TOTAL FEE CHARGED	
PATIENT PAYS	
DELTA PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

FORM DD/WV-0016-04-10