ATTENDING DENTIST'S STATEMENT

FOR D.D. USE ONLY

DELTA DENTAL

Fax Claims to 888-900-1373

DELTA DENTAL OF ARKANSAS
P.O. Box 15965
North Little Rock, Arkansas 72231
(800) 462-5410
(501) 835-3400

CHECK ONE: ☐ FOR PREDETERMINATION ☐ FOR PAYMENT

PATIENT SECTION

1. PATIENT NAME
2. RELATIONSHIP TO MEMBER — SELF ☐ SPOUSE ☐ DGHTR ☐ SON ☐ 3. OTHER ☐ M ☐ F
4. PATIENT BIRTHDATE — MO | DAY | YEAR
5. IF FULL TIME STUDENT — SCHOOL — CITY
6. EMPLOYEE/SUBSCRIBER NAME — FIRST MIDDLE LAST
7. EMPLOYEE/SUBSCRIBER ID
9. NAME OF GROUP DENTAL PROGRAM
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS — TELEPHONE NUMBER
10. EMPLOYER (COMPANY) NAME AND ADDRESS
CITY, STATE, ZIP
11. GROUP NUMBER
12. LOCATION (LOCAL)
13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME — I.D. NO. — BIRTHDATE
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? — DENTAL PLAN NAME — UNION LOCAL — GROUP NO. — NAME AND ADDRESS OF CARRIER

DENTIST SECTION

16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. Tax Identification No.
19. Dentist License No.
20. National Provider ID
21. Dentist Phone No.
22. FIRST VISIT DATE CURRENT SERIES
23. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER
24. RADIOGRAPHS OR MODELS ENCLOSED? — NO ☐ YES ☐ HOW MANY?
ATTACH X-RAYS SECURELY

	NO	YES	
25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	☐	☐	IF YES, ENTER BRIEF DESCRIPTION AND DATES
26. IS TREATMENT RESULT OF AUTO ACCIDENT?	☐	☐	
27. OTHER ACCIDENT?	☐	☐	
28. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	☐	☐	
29. IF PROSTHESIS OR SINGLE CROWN(S), IS THIS INITIAL PLACEMENT?	☐	☐	(IF NO, REASON FOR REPLACEMENT) — 30. DATE OF PRIOR PLACEMENT
31. IS TREATMENT FOR ORTHODONTICS?	☐	☐	IF SERVICES ALREADY COMMENCED, ENTER — DATE APPLIANCE PLACED — MOS. TREATMENT REMAINING

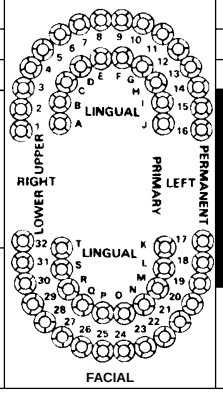
DIAGNOSTIC

DESCRIPTION	TOOTH # OR LETTER	SURFACE	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	DESCRIPTION OF SERVICE	TOOTH # OR LETTER	SURFACE	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE

32. REMARKS FOR UNUSUAL SERVICES

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

IDENTIFY MISSING TEETH WITH "X"



TOTAL FEES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE ABOVE HAVE BEEN PERFORMED ACCORDING TO THE PROVISIONS OF THE DENTAL CARE PLAN NAMED ABOVE. ALSO, THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THESE PROCEDURES. I AGREE TO THE TERMS AND CONDITIONS SET FORTH ON THE REVERSE OF THIS FORM AND PAYMENT FOR SAID PROCEDURES IS NOW DUE.

DENTIST SIGNATURE X _____ DATE _____

NATIONAL PROVIDER ID: _____

I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT THE PORTION OF THE DENTIST'S CHARGES COVERED UNDER THE DENTAL CARE PLAN NAMED ABOVE WILL BE PAID DIRECT TO THE DENTIST UNLESS THE DENTIST IS NOT PARTICIPATING WITH A DELTA PLAN AND I AM PERSONALLY RESPONSIBLE FOR ANY PORTION OF THOSE CHARGES NOT COVERED BY THE PLAN.

PATIENT (PARENT OR MEMBER) SIGNATURE X _____ DATE _____

MAIL ORIGINAL TO PLAN OR FAX TO 888-900-1373
RETAIN COPY FOR YOUR FILE.