

<b>HEADER INFORMATION</b>										<b>CARRIER NAME AND ADDRESS:</b>																							
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services – <b>OR</b> – <input type="checkbox"/> Request for Predetermination/Preauthorization										2. Delta Dental of Illinois 111 Shuman Blvd Naperville, IL 60563 (Please do not use for DeltaCare dental HMO)																							
<b>PRIMARY PAYER INFORMATION</b>										<b>OTHER COVERAGE</b>																							
3. Name, Address, City, State, Zip Code										16. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 17-23) <input type="checkbox"/> Yes (Complete 16-23)																							
<b>PRIMARY SUBSCRIBER INFORMATION</b>										17. Subscriber Name (Last, First, Middle Initial, Suffix)																							
4. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code										18. Date of Birth (MM/DD/CCYY)																							
5. Date of Birth (MM/DD/CCYY)										19. Gender <input type="checkbox"/> M <input type="checkbox"/> F																							
6. Gender <input type="checkbox"/> M <input type="checkbox"/> F										20. Subscriber Identifier (SSN or ID#)																							
7. Subscriber Identifier (SSN or ID#)										21. Plan/Group Number																							
8. Plan/Group Number										22. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																							
9. Employer Name										23. Other Carrier Name, Address, City, State, Zip Code																							
<b>PATIENT INFORMATION</b>																																	
10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other										11. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																							
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																	
13. Date of Birth (MM/DD/CCYY)										14. Gender <input type="checkbox"/> M <input type="checkbox"/> F																							
15. Patient ID/Account # (Assigned by Dentist)																																	
<b>RECORD OF SERVICES PROVIDED</b>																																	
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description										31. Fee																
1																																	
2																																	
3																																	
4																																	
5																																	
6																																	
7																																	
8																																	
9																																	
10																																	
<b>MISSING TEETH INFORMATION</b>		Permanent																Primary										32. Other Fee(s)					
34. (Place an 'X' on each missing tooth)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33.Total Fee					
		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						
35. Remarks																																	
<b>AUTHORIZATIONS</b>										<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>																							
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all 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.  X _____ Patient/Guardian signature Date										38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other										39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>													
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.  X _____ Subscriber signature Date										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										41. Date Appliance Placed (MM/DD/CCYY)													
										42. Months of Treatment Remaining										43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)				44. Date Prior Placement (MM/DD/CCYY)									
										45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																							
										46. Date of Accident (MM/DD/CCYY)										47. Auto Accident State													
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)										<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>																							
48. Name, Address, City, State, Zip Code										53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.  X _____ Signed (Treating Dentist) Date																							
49. Corporate Entity NPI (Type 2)										54. Individual NPI (Type 1)										55. License Number													
50. License Number										56. Address, City, State, Zip Code																							
51. SSN or TIN																																	
52. Phone Number ( ) -										57. Phone Number ( ) -										58. Treating Provider Specialty													