ATTENDING DENTIST'S STATEMENT

☐ DENTIST'S PREDETERMINATION REQUEST
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

DELTA DENTAL®

Delta Dental Plan of Tennessee
240 Venture Circle (615) 255-3175
Nashville, Tennessee 37228 CLAIM: (800) 223-3104

1. PATIENT	2. RELATIONSHIP TO SUBSCRIBER				3. SEX	4. PATIENT BIRTH DATE	5. FULL TIME STUDENT
	SELF ☐	SPOUSE ☐	CHILD ☐	OTHER ☐	☐M ☐F		☐ Yes ☐No
6. SUBSCRIBER NAME (First, Middle, Last)		7. SUBSCRIBER SOC. SEC. NO.				8. SUBSCRIBER BIRTH DATE	School City
SUBSCRIBER MAILING ADDRESS		10. EMPLOYER (COMPANY) NAME					PATIENT IS DEPENDENT UPON SUBSCRIBER FOR SUPPORT & MAINTENANCE AND HAS NEVER BEEN MARRIED
CITY, STATE, ZIP		(COMPANY ADDRESS)					☐ YES ☐ NO
11. GROUP NO.	IF PATIENT IS COVERED BY ANOTHER PLAN COMPLETE 13-15	13. SUBSCRIBER NAME				SOC. SEC. NO.	BIRTH DATE
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13		GROUP NO.	15. NAME AND ADDRESS OF CARRIER				AMOUNT OF PRIMARY PAYMENT

I HAVE REVIEWED THE TREATMENT PLAN SHOWN BELOW. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT , OR PARENT IF MINOR) DATE

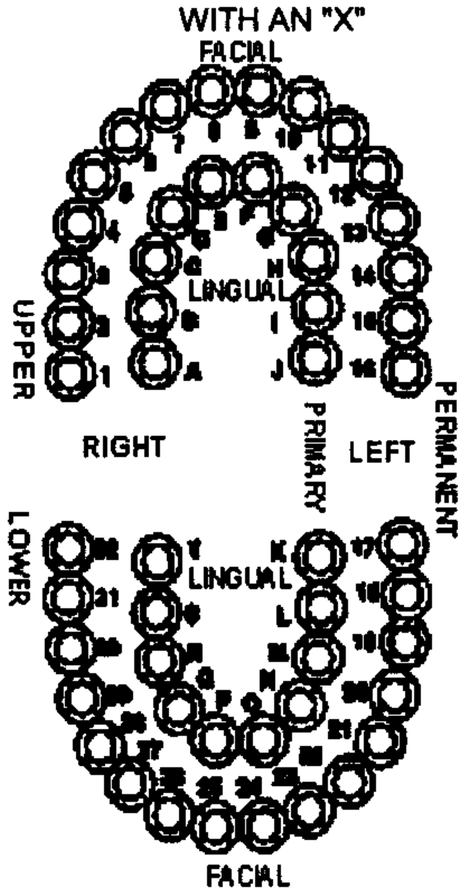
CHECK THIS BOX IF YOU WOULD LIKE FOR PAYMENT TO BE SENT TO YOUR DENTIST WHO IS A NON PARTICIPATING DENTIST ☐

PAYMENT AUTOMATICALLY GOES TO PARTICIPATING DENTIST

16. DENTIST NAME			24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS, INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS			25. IS TREATMENT RESULT OF AUTO ACCIDENT?	NO	YES	
CITY, STATE, ZIP			26. OTHER ACCIDENT?	NO	YES	
18. DENTIST SOC. SEC.NO. OR TIN	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.	27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	NO	YES	

21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT				23. RADIOGRAPHS OR MODELS ENCLOSED	NO	YES	HOW MANY	28. IS TREATMENT ORTHODONTICS	NO	YES	IF SERVICES ALREADY COMMENCED ENTER:	DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING
	OFFICE	HOSP.	RCP	OTHER										

IDENTIFY MISSING TEETH WITH AN "X"



30. REMARKS FOR UNUSUAL SERVICES

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

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPHYLASIX, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED	PROCEDURE NO.	FEE

I HAVE REVEIWED THE ABOVE TREATMENT PLAN. THE COURSE OF TREATMENT LISTED ABOVE IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST PRE-DETERMINATION

TOTAL FEE CHARGED

SIGNED (DENTIST) DATE

DEDUCTIBLE APPLIED

I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE, AND THE PROCEDURES WERE NECESSARY IN MY PROFESSIONAL JUDGEMENT

PATIENT'S TOTAL PAYMENT

DELTA'S PAYMENT

SIGNED (DENTIST) DATE

MAXIMUM USED