

Claim For Predetermination

Delta Dental of Virginia 4818 Starkey Road Roanoke, VA 24018 540-989-8000 or 800-237-6060 (Phone)

540-491-9717 ((Fax)
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EMPLOYEE/SUBSCRIBER INFORMAT	ION												
1. Name (First, MI, Last)						2. Subsc	riber Iden	tification No	3. Da	ate of Birth	ı	4. Gender	
						//		□ Male □ Female					
5. Mailing Address		6. Name Of Employer					I						
7. City, State, Zip		8. Group Number											
PATIENT INFORMATION													
9. Patient Name (First, MI, Last)						10. Rela	tionship to	Subscriber	11. C	Date of Bir	th	12. Gender	
						\Box Self \Box Spouse \Box Child \Box Other				1 1		□ Male □ Female	
13. If child age 19 or over	If Yes, Nam	ne of Schoo	bl				•						
-	Full Time Student: □ No □ Yes												
DTHER COVERAGE													
14. Is patient covered by another plan?	15. Type of I	Plan	16.	Name and Address o	f Carrier						17. Gro	oup No.	
□ No □ Yes (Complete 15-22)	□ Medical □												
18. Subscriber/Policyholder Name (First,			19.	Subscriber/Policyholo	ler ID	20. Date of	f Birth	21. Gender		22. Rela	tionship t	to Patient	
	,,			,		/	/	□ Male □ Fe	emale			□ Child □ Other	
DESCRIPTION					DATE	·						1	
DESCRIPTION	10	OOTH/ARE	A	SURFACE	DATE		PROCE	DURE CODE	DIAG	NOSIS CO	DDE(S)	FEE	
ANY SERVICE EXCE	EDING \$250												
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CLAIM MUST BE REC					E		ΤΟΤΑΙ	FEE CHARG	ED				
CLAIM MUST BE REC	EIVED WITHI			F DATE OF SERVIC		alacement?		-		at for orthog	dontics?		
CLAIM MUST BE REC TREATMENT INFORMATION Is treatment result of accident?	EIVED WITHI	IN ONE YE		F DATE OF SERVICE	is initial p			Yes Ist	reatmen			□ No □ Yes	
CLAIM MUST BE REC	es, Date injury?	IN ONE YE		F DATE OF SERVIC	is initial p al placen	nent		Yes Ist	reatmen te applia	nt for orthoo ance placed	d:	□ No □ Yes	
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