DELTA DENTAL®

☐ **Claim For Payment**

☐ **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)

EMPLOYEE/SUBSCRIBER INFORMATION

1. Name (First, MI, Last)	2. Subscriber Identification No	3. Date of Birth _____/_____/_____	4. Gender ☐ Male ☐ Female
5. Mailing Address		6. Name Of Employer	
7. City, State, Zip		8. Group Number	

PATIENT INFORMATION

9. Patient Name (First, MI, Last)	10. Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	11. Date of Birth _____/_____/_____	12. Gender ☐ Male ☐ Female
13. If child age 19 or over Full Time Student: ☐ No ☐ Yes	If Yes, Name of School		

OTHER COVERAGE

14. Is patient covered by another plan? ☐ No ☐ Yes (Complete 15-22)	15. Type of Plan ☐ Medical ☐ Dental	16. Name and Address of Carrier	17. Group No.

18. Subscriber/Policyholder Name (First, MI, Last)	19. Subscriber/Policyholder ID	20. Date of Birth _____/_____/_____	21. Gender ☐ Male ☐ Female	22. Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

DESCRIPTION	TOOTH/AREA	SURFACE	DATE	PROCEDURE CODE	DIAGNOSIS CODE(S)	FEE

ANY SERVICE EXCEEDING $250.00 SHOULD BE PRE-DETERMINED
CLAIM MUST BE RECEIVED WITHIN ONE YEAR OF DATE OF SERVICE

TOTAL FEE CHARGED

TREATMENT INFORMATION

Is treatment result of accident? ☐ No ☐ Yes, Date _____	If prosthesis: is this initial placement? ☐ No ☐ Yes	Is treatment for orthodontics? ☐ No ☐ Yes
Is treatment result of occupational illness or injury? ☐ No ☐ Yes	If No, Date of initial placement _____	Date appliance placed: _____
Radiographs or models enclosed? ☐ No ☐ Yes, How many?_____	(Enter reason for replacement in Remarks below)	Total months of treatment _____

REMARKS

AUTHORIZATION

I hereby authorize payment of the dentist benefits otherwise payable to me directly to the below named dental entity.

Employee/Subscriber Signature **X** Date

I accept this attending dentist's statement and authorize release of information relating hereto. I certify the truth of personal information contained above.
I agree to be responsible for payment for services provided during any ineligible period.

Patient/Guardian Signature **X** Date

BILLING DENTIST OR DENTAL ENTITY INFORMATION			**TREATING DENTIST INFORMATION**		
Name of Dentist or Dental Entity		Tax ID or SSN	Name Of Dentist		☐ DDS ☐ DMD ☐ LDH ☐ Denturist ☐ Lab Technician
Mailing Address		License No.	Mailing Address		License No.
City, State, Zip	Telephone No.	NPI	City, State, Zip	Telephone No.	NPI

TREATING DENTIST CERTIFICATION

(Treatment Completed-Payment Requested)	(Predetermination of Cost)
The treatment listed was completed and was necessary in my professional judgement. I request payment in accordance with DDVA participating dentist rules.	The treatment listed is necessary in my professional judgement and I request authorization in accordance with DDVA participating dentist rules.
Dentist Signature **X** Date	Dentist Signature **X** Date