

<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 P.O. Box 5402 Lisle, IL 60532 (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)		6. Gender <input type="checkbox"/> M <input type="checkbox"/> F		7. Subscriber Identifier (SSN or ID#)			19. Gender <input type="checkbox"/> M <input type="checkbox"/> F		20. Subscriber Identifier (SSN or ID#)																							
8. Plan/Group Number		9. Employer Name			21. 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																									
<b>PATIENT INFORMATION</b>					23. Other Carrier Name, Address, City, State, Zip Code																											
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)																											
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	
35. Remarks					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		
<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) _____					41. Date Appliance Placed (MM/DD/CCYY)																	
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)					42. Months of Treatment Remaining					43. Replacement of Prostheses? <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)					50. License Number					51. SSN or TIN					54. Individual NPI (Type 1)		55. License Number															
52. Phone Number ( ) -					57. Phone Number ( ) -					58. Treating Provider Specialty																						