Dental Claim Form

1.
☐ Dentist's pre estimate
☐ Dentist's statement of actual services
Provider ID #

2.
☐ Medicaid Claim
☐ EPSDT
Prior Authorization #
Patient ID #

3. Carrier name and address

DELTA DENTAL

DELTA DENTAL OF IDAHO
P.O.Box 2870
Boise, ID 83701
(208) 489-3580
FAX: (208) 344-4649

PATIENT COVERAGE INFORMATION

4. Patient name
first m.i. last

5. Relationship to employee
☐ self ☐ child
☐ spouse ☐ other _____

6. Sex
m f

7. Patient birthdate
MM DD YYYY

8. If full time student
school
city

9. Employee/subscriber name and mailing address

10. Employee/subscriber dental plan I.D. number

11. Employee/subscriber birthdate
MM DD YYYY

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan
yes no
If yes, complete 15-a.
Is patient covered by a medical plan? yes no

15-a. Name and address of carrier(s)

15-b. Group no.(s)

16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)

17-b. Employee/subscriber dental plan I.D. number

17-c. Employee/subscriber birthdate
MM DD YYYY

18. Relationship to patient
☐ self ☐ parent
☐ spouse ☐ other _____

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless 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 under applicable law, I authorize release of any information relating to this claim.

> _____ _____
Signed (Patient) Date

> _____ _____
Signed (Employee/subscriber) Date

BILLING DENTIST

20. Name of Billing Dentist or Dental Entity

21. Address where payment should be remitted

22. City, State, Zip

23. Dentist Soc. Sec. or T.I.N.

24. Dentist license no.

25. Dentist phone no.

26. First visit date current series

27. Place of treatment
Office Hosp. ECF Other

28. Radiographs or models enclosed? No Yes How many?

29. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates

30. Is treatment result of auto accident? No Yes

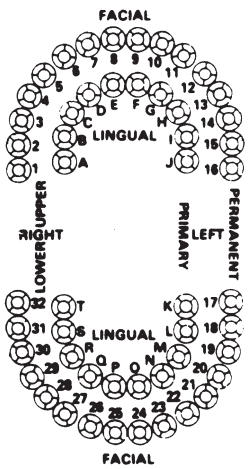
31. Other accident? No Yes

32. If prosthesis, is this initial placement? No Yes (if no, reason for replacement)

33. Date of prior placement

34. Is treatment for orthodontics? No Yes If service already commenced enter: Date appliances placed Mos. treatment remaining

35. Identify missing teeth with "x"



36. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

37. Remarks for unusual services

38. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

> _____
Signed (Treating Dentist) License Number Date

39. Address where treatment was performed

City State Zip

40. Total Fee Charged

41. Payment by other plan

Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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Idaho Code 41-286 Uniform Claims Processing requires all providers of health coverage in Idaho shall use a Uniform Claim Form effective 7/01/95.

DDI Claim 306a