
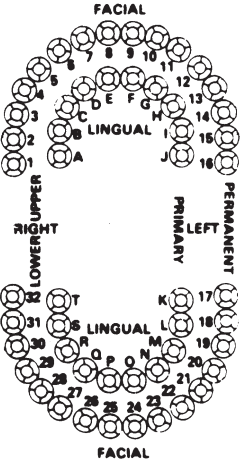


Dental Claim Form

1. <input type="checkbox"/> Dentist's pre estimate <input type="checkbox"/> Dentist's statement of actual services Provider ID #		2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization # Patient ID #		3. Carrier name and address <div style="text-align: right;">  DELTA DENTAL OF IDAHO P.O.Box 2870 Boise, ID 83701 (208) 489-3580 FAX: (208) 344-4649 </div>			
PATIENT COVERAGE INFORMATION	4. Patient name first _____ m.i. _____ last _____		5. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> 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 <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> 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				29. Is treatment result of occupational illness or injury? No _____ Yes _____		If yes, enter brief description and dates
	21. Address where payment should be remitted				30. Is treatment result of auto accident? No _____ Yes _____		
	22. City, State, Zip				31. Other accident? No _____ Yes _____		
	23. Dentist Soc. Sec. or T.I.N.	24. Dentist license no.	25. Dentist phone no.		32. If prosthesis, is this initial placement? No _____ Yes _____		(if no, reason for replacement)
	26. First visit date current series	27. Place of treatment Office _____ Hosp. _____ ECF _____ Other _____	28. Radiographs or models enclosed? No _____ Yes _____ How many? _____	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.					For administrative use only
		Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. ____ Day ____ Year ____	Procedure number	Fee
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.						40. Total Fee Charged	
> Signed (Treating Dentist) _____ License Number _____ Date _____						41. Payment by other plan	
39. Address where treatment was performed _____ City _____ State _____ Zip _____						Max. Allowable	
						Deductible	
						Carrier %	
						Carrier pays	
						Patient pays	