



Delta Dental of New York

PO Box 2105
Mechanicsburg, PA 17055-2105
717-766-8500 800-932-0783
TTY/TDD 888-373-3582

TRANSACTION AND PREDETERMINATION INFORMATION

13. Type of Transaction (Mark all Applicable Boxes)
Statement of Actual Services Request for Predetermination/Pre-treatment Estimate
EPSDT/ Title XIX Encounter

14. Predetermination/ Pre-treatment Estimate Number

TREATMENT INFORMATION

15. Treatment Resulting From
Occupational Illness/injury Auto accident Other accident

16. Date of Accident (MMDDCCYY) 17. Auto Accident State

18. Place of Treatment
Provider's Office Hospital ECF Other
19. Number of Enclosures (00 to 99)
Radiograph(s) Oral Image(s) Model(s)

20. Is Treatment for Orthodontics?
No (Skip 21-22) Yes (Complete 21-22)
21. Date Appliance Placed (MMDDCCYY)

22. Months of Treatment Remaining
23. Replacement of Prosthesis?
No Yes (Complete 44)
24. Date of Prior Placement (MMDDCCYY)

OTHER INSURANCE COVERAGE

25. Other Coverage? None Dental (Complete 26-32) Medical (Complete 26-32)
26. Name of Other Coverage Policyholder / Subscriber (Last, First, Middle Initial, Suffix)

27. Date of Birth (MMDDCCYY) 28. Gender M F 29. Policyholder / Subscriber ID (SSN or ID#)

30. Plan or Group Number 31. Patient's Relationship to Person Named in #26
Self Spouse Dependent Other

32. Other Insurance Company / Dental Benefit Plan Name, Address, City, State, ZIP Code

SUBSCRIBER INFORMATION

1. Policyholder / Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

2. Date of Birth (MMDDCCYY) 3. Gender M F 4. Policyholder / Subscriber ID (SSN or ID#)

5. Plan or Group Number 17958 6. Employer Name Walkill Teachers' Association

PATIENT INFORMATION

7. Relationship to Policyholder/Subscriber in #1 Above
Self Spouse Dependent Child Other

8. Patient Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

9. Date of Birth (MMDDCCYY) 10. Gender M F 11. Patient ID/Account # (Assigned by Dentist)

12. Remarks

33. Diagnosis Codes A. B. C. D.

RECORD OF SERVICES PROVIDED

Table with 10 columns: 34. Procedure Date, 35. Area of Oral Cavity, 36. Tooth Number(s) or Letter(s), 37. Tooth Surface, 38. Quantity, 39. Procedure Code, 40. Diagnosis Pointer (A, B, etc.), 41. Description, 42. Fee. Rows 1-8.

MISSING TEETH INFORMATION
Table with columns for Permanent (1-16) and Primary (A-J) teeth, and 43. Total Fee 0.00

AUTHORIZATION - RELEASE OF INFORMATION

45. 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

BILLING DENTIST OR DENTAL ENTITY

47. Dentist or Entity Name, Address, City, State, ZIP Code

48. NPI

49. License Number 50. SSN or TIN

51. Phone Number 52. Additional Provider ID

AUTHORIZATION - ASSIGNMENT OF BENEFITS

46. 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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as Indicated by date are in progress (for procedures that require multiple visits) or have been completed

X Signed (Treating Dentist) Date

54. Treatment Location Address, City, State, ZIP Code

55. NPI

56. License Number 57. Provider Specialty Code

58. Phone Number 59. Additional Provider ID