



Delta Dental of Pennsylvania

One Delta Drive
Mechanicsburg, PA 17055-6999
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ATTENDING DENTIST'S STATEMENT

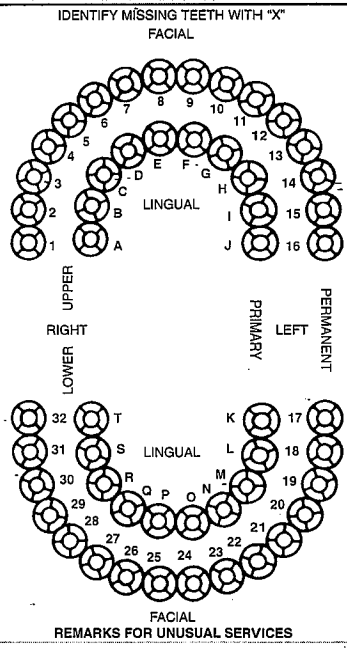
SIGN BELOW
FOR PREDETERMINATION
OR PAYMENT **

STAPLE X-RAYS TO FORM

1. PATIENT NAME, 2. RELATIONSHIP TO EMPLOYEE, 3. SEX, 4. PATIENT BIRTHDATE, 5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL, CITY, 6. EMPLOYEE/SUBSCRIBER NAME, 7. EMPLOYEE SOCIAL SECURITY NUMBER, 8. EMPLOYEE HOME ADDRESS, 9. EMPLOYER (COMPANY) NAME AND ADDRESS, 10. GROUP NUMBER, 11. DELTA - COVERED EMPLOYEE BIRTHDATE, 12. SPOUSE NAME, 13. SPOUSE BIRTHDATE, 14. NAME AND ADDRESS OF CARRIER, 15. SPOUSE SOCIAL SECURITY NUMBER

PLUMBERS & PIPEFITTERS
Local 520
Health & Welfare Fund

DENTIST NAME, MAILING ADDRESS, CITY, STATE, ZIP, DENTIST SOC. SEC. NO. OR FED. IDENT. NO., DENTIST LICENSE, DENTIST PHONE NO., FIRST VISIT DATE, PLACE OF TREATMENT, RADIOGRAPHS OR MODELS ENCLOSED?, HOW MANY?, DATE OF PRIOR PLACEMENT, IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?, IS TREATMENT RESULT OF AUTO ACCIDENT?, OTHER ACCIDENT?, IF PROSTHESIS, IS THIS INITIAL PLACEMENT?, IF NO, ENTER REASON FOR REPLACEMENT, DATE APPLIANCES PLACED, MONTHS TREATMENT REMAINING



EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN. Table with columns: TOOTH # OR LETTER, SURFACES MOI DLF, Description Of Service, DATE SERVICE PERFORMED, ADA PROCEDURE NUMBER, FEE.

* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS. I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT. PATIENT SIGNATURE, DATE, TOTAL FEE CHARGED, PATIENT PAYS, DELTA PAYS, AMOUNT APPLIED TO DEDUCTIBLE

FORM DD/PA-0016-01-10