DGA-PRODUCER PENSION & HEALTH

INSTRUCTIONS FOR THE DELTA DENTAL CLAIM FORM

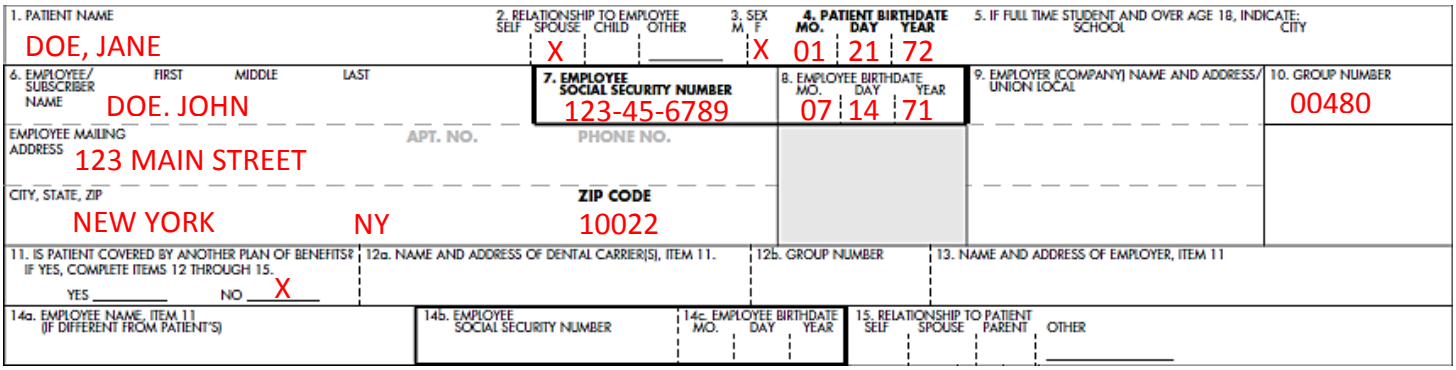
You should use this form if you are submitting a dental claim to Delta Dental for reimbursement. If you have numerous claims for a single individual that you are submitting at the same time, make sure some form of identifying information (name, social security number, etc.) appears on each individual claim.

Please use one claim form per individual. You cannot file one claim for multiple people.

If you have lost your Delta Dental ID card, you can call Delta Dental for a replacement at (800) 765-6003. If you are outside the United States, you can call (415) 972-8300.

FILLING OUT THE FORM

Be sure to complete sections 1, 2, 3, 4, 6, 7, 8, 10 and 11 as shown in the example below. The remaining sections may be left blank.



- **Box 1: Patient's Name**. Enter the name exactly as it appears on your Delta Dental ID card. If a dependent child does not have a Delta Dental ID card, enter the child's name as it appears on the birth certificate that was submitted to the Health Plan office.

- **Box 6: Employee/Subscriber Name.** Enter the name exactly as it appears on your Delta Dental ID card (See Box 1 above.) If you are also the patient, be sure to write your full name in both Box 1 and Box 6. Do not write "self" or "same" instead of your name.

- **Box 7: Employee SSN.** If you do not have a SSN, please use the Enrollee ID on your Delta Dental ID card.

- **Box 10: Insured's Policy Group or FECA Number.** Enter the Group Number that appears on your Delta Dental ID card.

- **Box 11: Another Plan of Benefits.** If you are not covered under another health plan, check no and you will not have to fill out the remaining information. Otherwise, please complete the remainder of the form.

Once completed, submit your form to **Delta Dental, P.O. Box 997330, Sacramento, CA 95899-7330**.

1. PLEASE TYPE OR PRINT
2. DO NOT USE A HIGHLIGHTER
3. STAPLE X-RAYS TO TOP RIGHT CORNER
4. SEND PAGE 1 TO DELTA

DELTA DENTAL OF CALIFORNIA ENCOURAGES DENTAL OFFICES TO SUBMIT CLAIMS ELECTRONICALLY.

DELTA DENTAL®
Delta Dental of California

P.O. Box 997330
Sacramento, CA 95899-7330
Customer Service (888) 335-8227

DELTA USE ONLY

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE: SELF SPOUSE CHILD OTHER
3. SEX: M F
4. **PATIENT BIRTHDATE** MO. DAY YEAR
5. IF FULL TIME STUDENT AND OVER AGE 18, INDICATE: SCHOOL CITY

6. EMPLOYEE/ SUBSCRIBER NAME: FIRST MIDDLE LAST
7. **EMPLOYEE SOCIAL SECURITY NUMBER**
8. EMPLOYEE BIRTHDATE MO. DAY YEAR
9. EMPLOYER (COMPANY) NAME AND ADDRESS/ UNION LOCAL
10. GROUP NUMBER

EMPLOYEE MAILING ADDRESS — APT. NO. — PHONE NO.
CITY, STATE, ZIP — **ZIP CODE**

11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES _____ NO _____
12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.
12b. GROUP NUMBER
13. NAME AND ADDRESS OF EMPLOYER, ITEM 11

14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)
14b. EMPLOYEE SOCIAL SECURITY NUMBER
14c. EMPLOYEE BIRTHDATE MO. DAY YEAR
15. RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

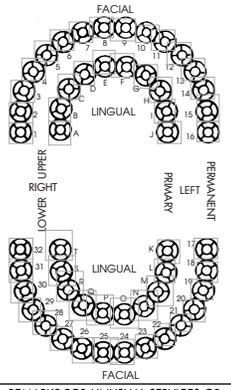
16. DENTIST NAME — **LICENSE NUMBER**
17. MAILING ADDRESS — PHONE NO.
CITY, STATE, ZIP — **ZIP CODE**

24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES
25. IS TREATMENT RESULT OF AUTO ACCIDENT? NO YES
26. OTHER ACCIDENT? NO YES
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN? NO YES
IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.

18. DENTIST SOC. SEC. NO. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT. NO YES
29. DATE OF PRIOR PLACEMENT

21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT: OFFICE HOSP. ECF OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?
30. IS TREATMENT FOR ORTHODONTICS? NO YES
IF SERVICES ALREADY COMMENCED, ENTER → DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32, USE CHARTING SYSTEM SHOWN.

TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y		PROCEDURE NUMBER	FEE	
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

32. REMARKS FOR UNUSUAL SERVICES OR **AMOUNT PAID BY OTHER COVERAGE**

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE.

SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____ DATE _____

You may receive a copy of this authorization on request.

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST A PREDETERMINATION OF COST.

DENTIST SIGNATURE _____ DATE _____

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM.

DENTIST SIGNATURE _____ DATE _____

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

1. SUBMIT PAGE 1 TO DELTA.
2. RETAIN PAGE 2 FOR YOUR FILES.

ATTENDING DENTIST'S STATEMENT
DELTA 105 Rev. 7/03