



- Claim For Payment
- Claim For Predetermination

Delta Dental of Virginia
4818 Starkey Road
Roanoke, VA 24018
540-989-8000 or 800-237-6060 (Phone)
540-491-9717 (Fax)

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|--|---------------------------------|------------------------------------|--|
| EMPLOYEE/SUBSCRIBER INFORMATION | | | |
| 1. Name (First, MI, Last) | 2. Subscriber Identification No | 3. Date of Birth ____/____/____ | 4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 5. Mailing Address | | 6. Name Of Employer LEIDOS | |
| 7. City, State, Zip | | 8. Group Number 700273 | |

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| PATIENT INFORMATION | | | |
| 9. Patient Name (First, MI, Last) | 10. Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | 11. Date of Birth ____/____/____ | 12. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 13. If child age 19 or over Full Time Student: <input type="checkbox"/> No <input type="checkbox"/> Yes | | If Yes, Name of School | |

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| OTHER COVERAGE | | | |
| 14. Is patient covered by another plan? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 15-22) | 15. Type of Plan <input type="checkbox"/> Medical <input type="checkbox"/> Dental | 16. Name and Address of Carrier | 17. Group No. |
| 18. Subscriber/Policyholder Name (First, MI, Last) | | 19. Subscriber/Policyholder ID | 20. Date of Birth ____/____/____ |
| | | 21. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | 22. Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |

| DESCRIPTION | TOOTH/AREA | SURFACE | DATE | PROCEDURE CODE | DIAGNOSIS CODE(S) | FEE |
|-------------|------------|---------|------|----------------|-------------------|-----|
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| ANY SERVICE EXCEEDING \$250.00 SHOULD BE PRE-DETERMINED CLAIM MUST BE RECEIVED WITHIN ONE YEAR OF DATE OF SERVICE | TOTAL FEE CHARGED |
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| TREATMENT INFORMATION | | |
| Is treatment result of accident? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date _____ | If prosthesis: is this initial placement? <input type="checkbox"/> No <input type="checkbox"/> Yes If No, Date of initial placement _____ | Is treatment for orthodontics? <input type="checkbox"/> No <input type="checkbox"/> Yes Date appliance placed: _____ |
| Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes | (Enter reason for replacement in Remarks below) | Total months of treatment _____ |
| Radiographs or models enclosed? <input type="checkbox"/> No <input type="checkbox"/> Yes, How many? _____ | | |

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| REMARKS |
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| AUTHORIZATION | |
| I hereby authorize payment of the dentist benefits otherwise payable to me directly to the below named dental entity. | |
| Employee/Subscriber Signature X | Date |
| I accept this attending dentist's statement and authorize release of information relating hereto. I certify the truth of personal information contained above. I agree to be responsible for payment for services provided during any ineligible period. | |
| Patient/Guardian Signature X | Date |

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| BILLING DENTIST OR DENTAL ENTITY INFORMATION | | | TREATING DENTIST INFORMATION | | |
| Name of Dentist or Dental Entity | | Tax ID or SSN | Name Of Dentist | | <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> LDH |
| Mailing Address | | License No. | Mailing Address | | <input type="checkbox"/> Denturist |
| City, State, Zip | | NPI | City, State, Zip | | <input type="checkbox"/> Lab Technician |
| Telephone No. | | | Telephone No. | License No. | |
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| TREATING DENTIST CERTIFICATION | |
| (Treatment Completed-Payment Requested) The treatment listed was completed and was necessary in my professional judgement. I request payment in accordance with DDVA participating dentist rules. | (Predetermination of Cost) The treatment listed is necessary in my professional judgement and I request authorization in accordance with DDVA participating dentist rules. |
| Dentist Signature X | Date |
| Dentist Signature X | Date |