DELTA DENTAL®

☐ **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)

EMPLOYEE/SUBSCRIBER INFORMATION

1. Name (First, MI, Last)	2. Subscriber Identification No	3. Date of Birth	4. Gender
		_____/_____/_____	☐ Male ☐ Female

5. Mailing Address	6. Name Of Employer
	LEIDOS
7. City, State, Zip	8. Group Number
	700273

PATIENT INFORMATION

9. Patient Name (First, MI, Last)	10. Relationship to Subscriber	11. Date of Birth	12. Gender
	☐ Self ☐ Spouse ☐ Child ☐ Other	_____/_____/_____	☐ Male ☐ Female

13. If child age 19 or over Full Time Student: ☐ No ☐ Yes	If Yes, Name of School

OTHER COVERAGE

14. Is patient covered by another plan? ☐ No ☐ Yes (Complete 15-22)	15. Type of Plan ☐ Medical ☐ 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	22. Relationship to Patient
		_____/_____/_____	☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Child ☐ Other

DESCRIPTION	TOOTH/AREA	SURFACE	DATE	PROCEDURE CODE	DIAGNOSIS CODE(S)	FEE

ANY SERVICE EXCEEDING $250.00 SHOULD BE PRE-DETERMINED
CLAIM MUST BE RECEIVED WITHIN ONE YEAR OF DATE OF SERVICE

TOTAL FEE CHARGED

TREATMENT INFORMATION

Is treatment result of accident? ☐ No ☐ Yes, Date _____	If prosthesis: is this initial placement? ☐ No ☐ Yes	Is treatment for orthodontics? ☐ No ☐ Yes
Is treatment result of occupational illness or injury? ☐ No ☐ Yes	If No, Date of initial placement _____	Date appliance placed: _____
Radiographs or models enclosed? ☐ No ☐ Yes, How many?_____	(Enter reason for replacement in Remarks below)	Total months of treatment _____

REMARKS

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

BILLING DENTIST OR DENTAL ENTITY INFORMATION

Name of Dentist or Dental Entity		Tax ID or SSN
Mailing Address		License No.
City, State, Zip	Telephone No.	NPI

TREATING DENTIST INFORMATION

Name Of Dentist		☐ DDS ☐ DMD ☐ LDH ☐ Denturist ☐ Lab Technician
Mailing Address		License No.
City, State, Zip	Telephone No.	NPI

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.

Dentist Signature **X** Date

(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