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

EMPLOYEE/SUBSCRIBER MUST COMPLETE SECTIONS 1-17

1. PATIENT NAME	2. RELATIONSHIP TO SUBSCRIBER: SELF / SPOUSE / CHILD / OTHER	3. SEX: M / F; 4. PATIENT BIRTHDATE: MO. DAY YEAR	5. IF CHILD AGE 19 OR OVER: FULL TIME STUDENT: NO ☐ YES ☐ NAME OF SCHOOL
6. SUBSCRIBER FNAME MI LNAME	7. SUBSCRIBER IDENTIFICATION NO	8. NAME OF EMPLOYER	**CORPORATE RISK HOLDINGS**
10. SUBSCRIBER MAILING ADDRESS		9. GROUP NUMBER	**600253**
11. CITY, STATE, ZIP			
12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO ☐ YES ☐ IF YES: →	13. EMPLOYEE NAME AND BIRTHDATE 16. NAME AND ADDRESS OF CARRIER	14. SUBSCRIBER ID NO.	15. EMPLOYER NAME 17. GROUP NO.
NAME OF DENTISTOR DENTAL ENTITY	TAX ID OR SOC. SEC. NO.	IS TREATMENT RESULT OF ACCIDENT? NO ❒ YES ❒ IF YES, DATE IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY NO ❒ YES ❒	
MAILING ADDRESS	LICENSE NO.	RADIOGRAPHS OR MODELS ENCLOSED? NO ❒ YES ❒ HOW MANY? IF PROSTHESIS: IS THIS INITIAL PLACEMENT? NO ❒ YES ❒ IF NO, ENTER REASON FOR REPLACEMENT AND DATE OF PLACEMENT IN REMARKS BELOW	
CITY, STATE & ZIP CODE	TELEPHONE NO.	IS TREATMENT FOR ORTHODONTICS? NO ❒ YES ❒ IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCE PLACED: MONTHS TREATMENT REMAINING:	

DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE	DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE
Periodic Exam				D0120		Extraction				D7140	
Limited Oral Eval				D0140		Extraction				D7140	
Comp Series-BW				D0210		Extraction				D7140	
Periapical 1st film				D0220							
Periapical EA Add ( )				D0230							
1-BW-X-Ray				D0270							
2-BW-X-Ray				D0272							
4-BW-X-Ray				D0274							
Panoramic Film				D0330							
Prophy – Adult				D1110							
Prophy – Child				D1120							
Fluoride – Child				D1203							
Sealant				D1351							
Amalgam 1SF				D2140							
Amalgam 1SF				D2140							
Amalgam 1SF				D2140							
Amalgam 2SF				D2150							
Amalgam 2SF				D2150							
Amalgam 3SF				D2160							
Amalgam 3SF				D2160							
Amalgam 4SF				D2161				TOTAL FEE			
Comp 1SF (Ant)				D2330				CHARGED			
Comp 1SF (Ant)				D2330							
Comp 1SF (Ant)				D2330							
Comp 2SF (Ant)				D2331							
Comp 3SF (Ant)				D2332							
Comp 1SF (Post)				D2391							
Comp 1SF (Post)				D2391							
Comp 1SF (Post)				D2391							
Comp 2SF (Post)				D2392							
Comp 3SF (Post)				D2393							
Pulpotomy				D3220							
RCT-Ant				D3310							
RCT-Bicsp				D3320							
RCT-Molar				D3330							
Perio Scal/Rt Plan				D4341							
Perio Maint				D4910							

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

REMARKS FOR UNUSUAL SERVICES

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 (PARENT OR EMPLOYEE) SIGNATURE x DATE

(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