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®

P.O. Box 997330
Sacramento, California 95899-7330

DELTA USE ONLY

Customer Service: 888-335-8227
www.deltadentalins.com

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 OVER 18, INDICATE: SCHOOL / CITY

6. EMPLOYEE/ SUBSCRIBER NAME: FIRST / MIDDLE / LAST | **7. EMPLOYEE** SOCIAL SECURITY NUMBER | 8. EMPLOYEE BIRTHDATE MO. / DAY / YEAR | 9. EMPLOYEE (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 / CHILD / OTHER

16. DENTIST NAME | **LICENSE NUMBER**

17. MAILING ADDRESS | PHONE NO.

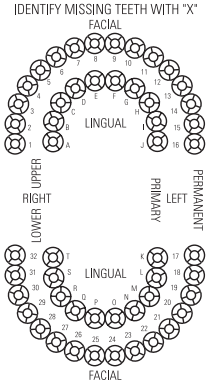
CITY, STATE, ZIP | **ZIP CODE**

	NO	YES	IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO ENTER REASON FOR REPLACEMENT.			29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?	NO	YES	IF SERVICES ALREADY COMMENCED ENTER → DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

18. DENTIST SOC. SEC. NO. OR T.I.N. | 19. DENTIST LICENSE NO. | 20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT: OFFICE / HOSP. / ECF / OTHER | 23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY

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 THE DATE.

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

You may receive a copy of this authorization on request.

TOTAL FEE CHARGED

PATIENT PAYS

DELTA PAYS

AMOUNT APPLIED TO DEDUCTIBLE

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST 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 ABVOE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY TO STATE ON THIS FORM.

DENTIST SIGNATURE DATE

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

ATTENDING DENTIST'S STATEMENT

Delta 105 (rev. 11/07) #44555

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