DELTA DENTAL®

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TTY/TDD 888-373-3582
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ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION *
OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME | 2. RELATIONSHIP TO EMPLOYEE: SELF SPOUSE CHILD OTHER | 3. SEX: M F | IMPORTANT 4. PATIENT BIRTHDATE MO. DAY YR. | 5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL CITY

6. EMPLOYEE/ SUBSCRIBER NAME: LAST FIRST MIDDLE INITIAL | IMPORTANT 7. SUBSCRIBER I.D. NUMBER | OR 1 OR 2 OR 3 OR 4 OR 5 OR 6

8. EMPLOYEE HOME ADDRESS

CITY, STATE ZIP — ZIP CODE

9. EMPLOYER (COMPANY) NAME AND ADDRESS: UUP Benefit Trust Fund - Active Members

10. GROUP NUMBER: 0165

IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15

11. DELTA - COVERED EMPLOYEE BIRTHDATE MO. DAY YR.

12. SPOUSE NAME

13. SPOUSE BIRTHDATE MO. DAY YR.

14. NAME AND ADDRESS OF CARRIER

15. SPOUSE I.D. NUMBER

DENTIST NAME

MAILING ADDRESS

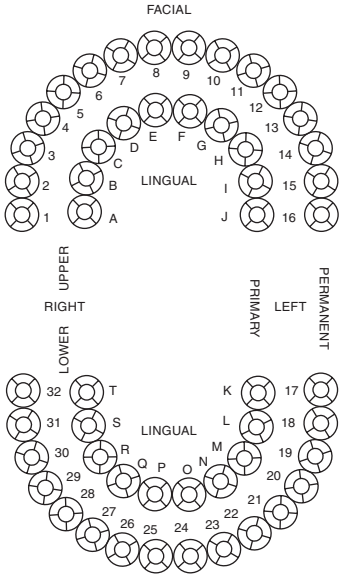
CITY, STATE ZIP

DENTIST I.D. NUMBER | DENTIST LICENSE | DENTIST PHONE NO.

FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT: OFFICE OTHER | RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ | HOW MANY?

	NO	YES	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT?			
OTHER ACCIDENT?			
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, ENTER REASON FOR REPLACEMENT
DATE OF PRIOR PLACEMENT			
IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER:
DATE APPLIANCES PLACED			
MONTHS TREATMENT REMAINING			

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

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

TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YR.	ADA PROCEDURE NUMBER	FEE
		1			
		2			
		3			
		4			
		5			
		6			
		7			
		8			
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Pursuant to law, please be advised that any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

* PREDETERMINATION OF COSTS
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS

DENTIST SIGNATURE _____ DATE _____

** TREATMENT COMPLETED – PAYMENT REQUESTED
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.

DENTIST SIGNATURE _____ DATE _____

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.

PATIENT SIGNATURE _____

DATE _____

TOTAL FEE CHARGED	
PATIENT PAYS	
DELTA PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

FORM DD/NY-0016-04-10