DELTA DENTAL®

CLAIM FORM

ATTENDING DENTIST'S STATEMENT

FOR DDKS USE ONLY

Delta Dental of Kansas
P.O. Box 789769
Wichita, KS 67278-9769

CHECK ONE: ☐ FOR PREDETERMINATION ☐ FOR PAYMENT

PATIENT SECTION

1. PATIENT NAME (FIRST / MIDDLE / LAST)	2. RELATIONSHIP TO PATIENT	3. SEX M F	4. PATIENT BIRTH DATE MM DD YY	5. IF FULL-TIME STUDENT OVER AGE 19 SCHOOL / CITY
	☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____			

6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS	7. EMPLOYEE/SUBSCRIBER MEMBER NUMBER	8. EMPLOYEE/SUBSCRIBER BIRTH DATE	9. EMPLOYER (COMPANY)
			10. GROUP NUMBER

12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN (IF YES, COMPLETE 13-15) ☐ YES ☐ NO IS PATIENT COVERED BY A MEDICAL PLAN? ☐ YES ☐ NO	13A. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)	13B. EMPLOYEE/SUBSCRIBER MEMBER NUMBER	13C. EMPLOYEE/SUBSCRIBER BIRTH DATE	13D. RELATIONSHIP TO PATIENT ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER _____

14. NAME AND ADDRESS OF EMPLOYER	15A. NAME AND ADDRESS OF CARRIER (S)	15B. GROUP NO (S)
		15C. AMOUNT PAID BY OTHER INSURANCE

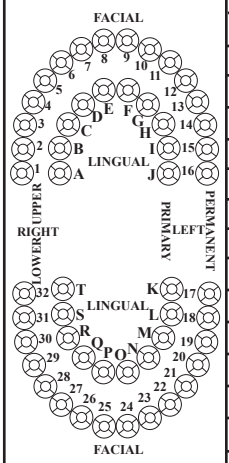
I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT THE PORTION OF THE DENTIST'S CHARGES COVERED UNDER THE DENTAL CARE PLAN NAMED ABOVE WILL BE PAID DIRECTLY TO THE DENTIST, UNLESS THE DENTIST IS NOT A PARTICIPATING DENTIST WITH DELTA DENTAL OF KANSAS IN WHICH CASE PAYMENT WILL BE MADE DIRECTLY TO THE SUBSCRIBER.

PATIENT (PARENT OR EMPLOYEE) SIGNATURE X_____ DATE _____

DENTIST SECTION

16. DENTIST NAME OR BUSINESS NAME / DENTIST PHONE NO.	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
CITY, STATE, ZIP	26. OTHER ACCIDENT?			
18. DENTIST SOC. SEC. OR T.I.N. / 19. DENTIST LICENSE NO. / 20. DENTIST NPI NO.	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) / 29. DATE OF PRIOR PLACEMENT
21. FIRST VISIT DATE / CURRENT DATE — 22. PLACE OF TREATMENT: OFFICE ☐ HOSP ☐ ECF ☐ OTHER ☐	23. X-RAYS, PHOTOS, MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?	30. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCE ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



32. TOOTH # OR LETTER	33. ARCH SURFACE OR QUAD	34. DESCRIPTION OF SERVICE	35. DATE SERVICE COMPLETED MO. DAY YEAR	36. PROC CODE	37. FEE	32. TOOTH # OR LETTER	33. ARCH SURFACE OR QUAD	34. DESCRIPTION OF SERVICE	35. DATE SERVICE COMPLETED MO. DAY YEAR	36. PROC CODE	37. FEE
		Periodic Oral Evaluation		0120				Amalgam		21 _ _	
		Ltd. Oral Eval.-Problem Focused		0140				Amalgam		21 _ _	
		Comprehensive Oral Evaluation		0150				Amalgam		21 _ _	
		Detailed Oral Eval.-Problem Focused		0160				Composite - Resin		23 _ _	
		Complete series-radiographic images		0210				Composite - Resin		23 _ _	
		1st P.A. radiographic image		0220				Composite - Resin		23 _ _	
		( ) Add'l P.A. radiographic image		0230				R.C.T. Anterior		3310	
		Bitewing - 1 Radiographic Image		0270				R.C.T. Bicuspid		3320	
		Bitewings - 2 Radiographic Images		0272				R.C.T. Molar		3330	
		Bitewings - 3 Radiographic Images		0273				Root Planing/Scaling		434 _	
		Bitewings - 4 Radiographic Images		0274				Root Planing/Scaling		434 _	
		Panoramic		0330				Perio Maintenance		4910	
		Adult Prophy		1110				Extraction		7140	
		Child Prophy (through age 13)		1120				Extraction		7140	
		Fluoride application		12 _ _							

38. REMARKS FOR UNUSUAL SERVICES

TOTAL FEE CHARGED

39. I HEREBY CERTIFY THAT THE PROCEDURES, AS INDICATED BY DATE, HAVE BEEN COMPLETED BY ME AND WERE NECESSARY IN MY PROFESSIONAL JUDGMENT AND THAT THE FEE SHOWN IS MY USUAL FEE AND THE FEE I INTEND TO COLLECT EXCEPT WHERE NOTED. I REQUEST PAYMENT IN ACCORDANCE WITH DDKS RULES AND REGULATIONS.

X_____ SIGNED (TREATING DENTIST) | LICENSE NUMBER | NPI NUMBER | DATE

40. ADDRESS WHERE TREATMENT WAS PERFORMED, IF DIFFERENT THAN MAILING ADDRESS.

ADDRESS | CITY | STATE | ZIP

Rev. 2/13