

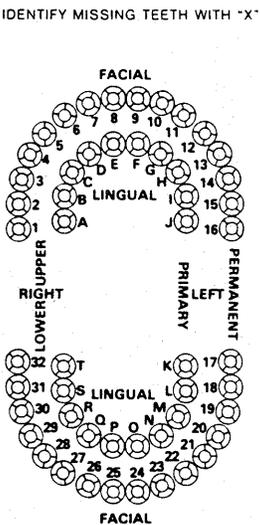
1. PATIENT NAME - PLEASE PRINT FIRST LAST		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F	4. PATIENT BIRTHDATE MO DAY YR		5. IF FULL TIME STUDENT OVER AGE 18 CITY, STATE SCHOOL NAME			
6. EMPLOYEE/SUBSCRIBER NAME FIRST LAST			7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.		10. NAME OF EMPLOYER, UNION OR TRUST FUND				JAN	FEB
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS CITY STATE ZIP			9. EMPLOYEE/SUBSCRIBER BIRTHDATE		11. EMPLOYER ADDRESS				MAR	APR
									MAY	JUN
									JUL	AUG
									SEP	OCT
									NOV	DEC
12. GROUP NUMBER		13. UNION LOCAL NO.		14. IS PATIENT COVERED BY ANOTHER PLAN? NO <input type="checkbox"/> YES <input type="checkbox"/>		15. IF YES, ATTACH PRIMARY CARRIER PAYMENT EXPLANATION. NO <input type="checkbox"/> YES <input type="checkbox"/>				
16. LIST OTHER FAMILY MEMBERS EMPLOYED WITH BENEFIT COVERAGE. EMPLOYEE NAME RELATIONSHIP SOC. SEC. NO.				BIRTHDATE MO DAY YR		DENTAL PLAN NAME		GROUP NO.		

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL HISTORY, CONDITION OR TREATMENT, AS NEEDED TO DETERMINE BENEFITS RELATED TO THE DENTAL WORK FOR WHICH THIS CLAIM IS MADE. I UNDERSTAND AND AGREE WITH THE TREATMENT RECOMMENDED AND SUBMITTED ON THIS FORM. I CERTIFY THAT THE INFORMATION IN BLOCKS 1 THROUGH 17 IS TRUE AND CORRECT.

17. SIGNATURE OF PATIENT (or parent or guardian) _____ DATE _____

18. DENTIST NAME		26. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES		IF YES, ENTER BRIEF DESCRIPTION AND DATES.	
19. MAILING ADDRESS CITY STATE ZIP		27. IS TREATMENT RESULT OF AUTO ACCIDENT? NO YES			
20. DENTIST SOC. SEC. NO. OR TAX ID NO.		21. DENTIST LICENSE NO. STATE		22. DENTIST PHONE NO. ()	
23. PREDETERMINATION NO <input type="checkbox"/> YES <input type="checkbox"/>		24. PAR N PAR		25. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?	
				29. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO YES	
				IF NO, REASON FOR REPLACEMENT? DATE OF PRIOR PLACEMENT.	
				30. IS TREATMENT FOR ORTHODONTICS? NO YES	
				IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED. MOS TREATMENT REMAINING.	

31. EXAMINATION AND TREATMENT PLAN - USE CHARTING SYSTEM SHOWN							FOR DELTA USE ONLY	
TOOTH OR QUAD	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED			PROCEDURE NUMBER	DENTIST FEE	
			MO	DAY	YR			
		1						
		2						
		3						
		4						
		5						
		6						
		7						
		8						
		9						
		10						
		11						
		12						
		13						
		14						
		15						



32. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

33. DENTIST'S SIGNATURE _____ DATE _____

TOTAL FEE CHARGED _____

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental Plan of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts to Delta participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.