DELTA DENTAL

Delta Dental of Minnesota

ATTENDING DENTIST'S STATEMENT

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Carrier name and address

Delta Dental of Minnesota
P. O. Box 330
Minneapolis, MN 55440-0300

PATIENT COVERAGE INFORMATION

1. Patient name — first / m.i. / last

2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other ________

3. Sex — m / f

4. Patient birthdate — MM / DD / YYYY

5. If full time student — school / city

6. Employee/subscriber name and mailing address

7. Employee/subscriber soc. sec. or I.D. number

8. Employee/subscriber birthdate — MM / DD / YYYY

9. Employer (company) name and address: Pearson, Inc

10. Group number: 050527

11. Is patient covered by another dental plan? yes no
If yes, complete 12-a.
Is patient covered by a medical plan? yes no

12-a. Name and address of carrier(s)

12-b. Group no.(s)

13. Name and address of other employer(s)

14-a. Employee/subscriber name (if different than patient's)

14-b. Employee/subscriber soc. sec. or I.D. number

14-c. Employee/subscriber birthdate — MM / DD / YYYY

15. Relationship to patient — ☐ self ☐ parent ☐ spouse ☐ other ________

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (Patient, or parent if minor) ________ Date ________

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (Insured person) ________ Date ________

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity

17. Address where payment should be remitted

City, State, Zip

18. Dentist Soc. Sec. 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?

	No	Yes	If yes, enter brief description and dates
24. Is treatment result of occupational illness or injury?			
25. Is treatment result of auto accident?			
26. Other accident?			
27. If prosthesis, is this initial placement?			(If no, reason for replacement) / 28. Date of prior placement
29. Is treatment for orthodontics?			If services already commenced enter: / Date appliances placed: / Mos. treatment remaining

Identify missing teeth with "x"

FACIAL / LINGUAL / UPPER / LOWER / RIGHT / LEFT / PRIMARY / PERMANENT — teeth 1–32 and A–T

30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo.	Day	Year	Procedure number	Fee

For administrative use only

31. 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.

Signed (Treating Dentist) ________ License Number ________ Date ________

Total Fee Charged

Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

In accordance with 0512

12/06

See back of ID Card for customer service telephone number.