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	3. Sex	4. Patient birthdate	5. If full time student (school / city)
	☐ self ☐ child ☐ spouse ☐ other _____	m f	MM DD YYYY	

6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate	9. Employer (company) name and address	10. Group number
		MM DD YYYY	Pearson Education, Inc	655331

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

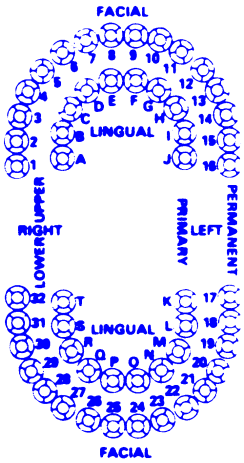
BILLING DENTIST

16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
17. Address where payment should be remitted	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 phone no.	27. If prosthesis, is this initial placement?			(If no, reason for replacement)	28. Date of prior placement

21. First visit date current series	22. Place of treatment: Office / Hosp. / ECF / Other	23. Radiographs or models enclosed	No	Yes	How many?	29. Is treatment for orthodontics?			If services already commenced enter:	Date appliances placed:	Mos. treatment remaining

Identify missing teeth with "x"



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.