

NORTHEAST DELTA DENTAL
One Delta Drive
P.O. Box 2002
Concord, N.H. 03302-2002
(603) 223-1234
(800) 832-5700
DELTA DENTAL PLAN OF MAINE
DELTA DENTAL PLAN OF NEW HAMPSHIRE
DELTA DENTAL PLAN OF VERMONT

PLEASE MAKE SURE EMPLOYEES MAILING ADDRESS IS LEGIBLE, CURRENT AND CORRECT

PATIENT SECTION
1. PATIENT NAME (FIRST MIDDLE LAST)
2. RELATIONSHIP TO EMPLOYEE
3. SEX
4. PATIENT BIRTHDATE
5. IF 19 YEARS OLD AND FULL TIME STUDENT
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec./ID no.
8. Employee/subscriber birthday
9. Employer (company) name and address
10. Group Number
11. Is patient covered by another plan of benefits?
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of employer
14-a. Employee/subscriber name
14-b. Employee/subscriber soc. sec. number
14-c. Employee/subscriber birthdate
15. Relationship to patient

DENTIST SECTION
16. DENTIST NAME
17. MAILING ADDRESS
18. DENTIST SOC. SEC. OR TIN #
19. DENTIST STATE LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE OR CURRENT SERIES
22. PLACE OF TREATMENT OFFICE
23. RADIOGRAPHS OR MODELS ENCLOSED?
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?
25. IS TREATMENT RESULT OF AUTO ACCIDENT?
26. OTHER ACCIDENT
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?
29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?
IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MDS, TREATMENT REMAINING

31. Examination and Treatment Plan - List in Order from Tooth No. 1 through Tooth No. 32 - Use Charting System shown
Table with columns: Tooth # or Letter, Surfaces, Description of Service, Start Date of Multiple Appointment Procedure, Completion Date, For Delta Use Only, Procedure Number, Fee, These Columns For Delta Use Only, POLICY

PLEASE SEE REVERSE SIDE FOR DEFINITION OF INCURRED DATES (DATE OF SERVICE), IMPORTANT, ALTHOUGH THE INCURRED DATE IS USED FOR DETERMINING LIABILITY, A SERVICE MUST NEVER BE BILLED UNTIL COMPLETED. PLEASE INDICATE TOTAL FEE CHARGED

\*PREDETERMINATION OF COSTS: THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST PREDETERMINATION ON THESE SERVICES IN ACCORDANCE WITH PLAN RULES AND REGULATIONS.
36. PRE-TREATMENT RADIOGRAPHS REQUIRED FOR DENTAL CONSULTANT'S REVIEW.
37. FEE BREAKDOWN REQUIRED BY PROCEDURE CODE.
38. CHARTING REQUIRED FOR DENTAL CONSULTANT'S REVIEW.

33. DENTIST SIGNATURE DATE
\*\*TREATMENT COMPLETED - PAYMENT REQUESTED I HEREBY CERTIFY THAT I HAVE COMPLETED THE PROCEDURES AS INDICATED BY DATE OF SERVICE, I REQUEST PAYMENT IN ACCORDANCE WITH PLAN RULES AND REGULATIONS.
34. DENTIST SIGNATURE DATE
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THE CLAIM. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED DURING ANY INELIGIBLE PERIOD AND/OR NOTE COVERED BY BY PREPAYMENT PROGRAM.
35. SIGNED (PATIENT, OR PARENT IF MINOR)

Table with 38 numbered cells (1-38) for marking missing data needed to process claim.

MARKED NUMBERS ABOVE (1-38) REFER TO MISSING DATA NEEDED TO PROCESS CLAIM.

IF MORE THAN 15 PROCEDURES ARE PERFORMED OR PLANNED, PLEASE COMPLETE ANOTHER ATTENDING DENTIST'S STATEMENT. ADS (99)

Table with columns: MAXIMUM APPROVED, AMOUNT APPLIED TO DEDUCTIBLE, DELTA PAYS, PATIENT PAYS



DATE OF INCURRED LIABILITY - A service shall be deemed to have been incurred and the total cost for that service subject to applicable deductible, co-payment percentage, maximum benefit, and limitations shall be applied to the contract year during which the service was incurred, irrespective of the contract year during which the service is completed, according to the following:

PLEASE NOTE: Although the “Start Date” column should indicate the date treatment was initiated (in accordance with Delta’s definition of “Date of Incurred Liability”), payment should never be requested until the procedure is completed and that date entered into the “Completion Date” column.

- (a) Restorative Crowns. Total cost for crowns and jackets shall be incurred on the date that the tooth is prepared to receive said appliance.
- (b) Fixed Bridge (Abutment Crowns and Pontics). Total cost for fixed bridges shall be incurred on the date that the first tooth is prepared to receive said appliance.
- (c) Removable Bridgework (Removable Dentures). Total cost for removable bridgework (dentures) shall be incurred on the date that the final impressions are taken for said appliance.
- (d) Endodontics. Total cost for endodontic treatment shall be incurred when the pulp chamber of the tooth is opened for the root canal.
- (e) Implants. Total cost for an allowance toward a prosthesis used in conjunction with an implant shall be incurred on the date that the impression is taken for said prosthesis.

COMPLETION OF TREATMENT - NEDD does not make payment for incomplete treatment unless terminated due to death of patient. To qualify as a covered service, a service must be completed and, if applicable, “delivered” to the patient.