



Delta Dental of Pennsylvania

One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION *
OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

Form sections 1-15: Patient Name, Relationship to Employee, Sex, Birthdate, Social Security Number, Employee Name, Home Address, Employer Name, Group Number, Spouse Name, Spouse Birthdate, Spouse Social Security Number, Carrier Name, Spouse Social Security Number.

Form sections 16-20: Dentist Name, Mailing Address, City/State/Zip, Dentist Soc. Sec. No., Dentist License, Dentist Phone No., First Visit Date, Place of Treatment, Radiographs, How Many, Date of Prior Placement, Treatment for Orthodontics, Services Commenced, Date Appliances Placed, Months Treatment Remaining.

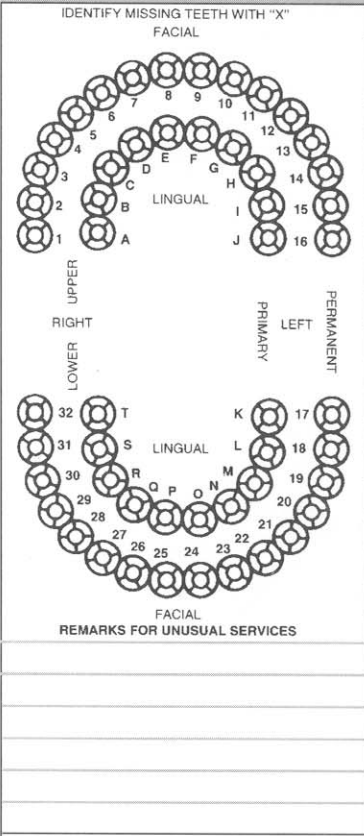


Table with 6 columns: Tooth # or Letter, Surfaces (MOI, DLF), Description of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.), Date Service Performed (MO, Day, Yr), ADA Procedure Number, Fee. Rows 1-23.

* PREDETERMINATION OF COSTS
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS.
DENTIST SIGNATURE DATE
** TREATMENT COMPLETED - PAYMENT REQUESTED
THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.
DENTIST SIGNATURE DATE

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.
PATIENT SIGNATURE DATE

Summary table with columns: TOTAL FEE CHARGED, PATIENT PAYS, DELTA PAYS, AMOUNT APPLIED TO DEDUCTIBLE.

FORM DD/PA-0016-97-12