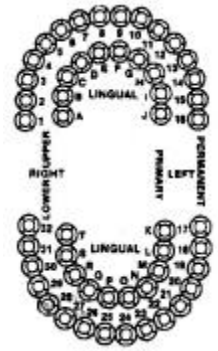
**DELTA DENTAL**
P.O. Box 9085
Farmington Hills, Michigan 48333-9085

DENTIST' STATEMENT OF ACTUAL SERVICES ☐ | DENTIST'S PRE-DETERMINED REQUEST ☐

## PATIENT & SUBSCRIBER INFORMATION

| 1. Patient Name First Last Middle | 2. Patient Relationship to Subscriber Self ☐ Spouse ☐ Child ☐ Other ☐ | 3. Patient Sex Male ☐ Female ☐ | 4. Patient Birthdate |
|---|---|---|---|
| 5. Subscriber Soc. Sec. No. | 6. Subscriber Birthdate | 7. Group Number | 8. If patient is a dependent over 19, Please indicate status and sign on Line 11 Full Time Student ☐ Totally & Perm. Disabled ☐ IRS Dependent ☐ Sponsored Dependent ☐ |
| 9. Subscriber Name First Last Middle | | | 8a. Only for states allowing assignment (See Reverse): I hereby assign and authorize payment ☐ of the group dental benefits otherwise payable to me to the below named dentist |
| 10. Subscriber Mailing Address | | | 11. Subscriber Signature Date |
| 12. City | State | Zip | 13. Employer/Company Name |

| If patient is covered by another plan, complete items 14-24<br>14. Subscriber name First Last Middle Initial | 15. Soc. Sec. No. | 16. Birthdate | 17. Group Number | 18. Amount of Primary Payment<br>$ |
|---|---|---|---|---|
| 19. Mailing Address | | | 22. Name of other carrier | |
| 20. City | State | Zip Code | 23. Carrier Address | |
| 21. Name of Employer | | | 24. City | State / Zip Code |




## PROVIDER INFORMATION

| 25. Provider Business Name | 26. Provider T.I.N. (or SSN) | | |
|---|---|---|---|
| 27. Service Office Address (Number/Street) | 28. DDS LIC. NO. | 29. State | 30. SPEC. CD. |
| 31. City / State / Zip Code | 32. Dentist Phone No. ( ) | | |

| 33. No ❑ Yes ❑<br>IS TREATMENT RESULT OF OCCUPATIONAL INJURY? | 34. No ❑ Yes ❑ ➪ How Many ❑<br>RADIOGRAPHS OR MODELS ENCLOSED? | 35.a. No ❑ Yes ❑ ➪<br>IS TREATMENT RELATED TO ORTHODONTICS? | .35b. MM DD CC/YY<br>IF SERVICE ALREADY COMMENCED, DATE APPLIANCES PLACED | 35.c. Number<br>OF ACTIVE MONTHS OF TREATMENT |
|---|---|---|---|---|

**Carefully form characters as shown**

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0 1 2 3 4 5 6 7 8

| TOOTH NUMBER OR LETTER | SURFACE | DATE SERVICE PERFORMED | PROCEDURE NUMBER | FEE $ Dollars Cents |
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**DO NOT TYPE IN SHADED AREA**

Remarks

$
TOTAL FEE CHARGED

I hereby certify that I have performed the procedures as indicated by date and/or wish to predetermine the procedures which are not dated and the procedures were/are necessary in my professional judgement

| Signed (Dentist) | Date |
|---|---|
| | |