Dental Plan Claim Form Delta Dental of Kentucky

Policyholder

1. Policyholder SSN/ID#	2. Birth Date - -	3. Gender
4. Policyholder Name (Last, First, M.I., Suffix)		
5. Policyholder Address		
6. Policyholder City, State, Zip		
7. Policyholder Employer	8. Plan/Group #	

I hearby authorize and direct payment of the dental benefits otherwise payable to me, directly to the named dentist or dental entity.

Signed: _____ Date: - -

Patient

9. Patient Name (Last, First, M.I., Suffix)		10. Gender
11. Relationship to Policyholder	12. Birth Date - -	13. Student ☐

I have been informed of the treatment plan and associated fees. I agree to be responsible for charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signed: _____ Date: - -
Parent or Guardian

Insurance Information

14. Primary Insurance Company					
15. Primary Insurance Address, City, State, Zip					16. Primary Insurance Payment
17. Transaction Type: ☐ Statement of Service ☐ Request for Predetermination/Preauthorization					
Other Coverage					
18. Secondary Coverage: ☐ Yes ☐ No If Yes: ☐ Dental ☐ Medical			19. Name of Policyholder (Last, First, M.I., Suffix)		
20. Relationship to Policyholder	21. Birth Date - -	22. Gender	23. Covered SSN/ID#		24. Plan/Group #
25. Secondary Insurance Company			26. Predetermination/Preauthorization Number		
27. Secondary Insurance Address, City, State, Zip					

Ancillary Information

28. Place of Treatment (circle):	Provider's Office	Hospital	ECF	
29. Number of enclosures (0 to 99):	Radiograph(s):	Oral Image(s):	Model(s):	Charting:
30. Prosthesis Placed: ☐ Initial Placement ☐ Prior Placement			31. Prior Placement Date - -	
32. Treatment resulting from: ☐ Occupational Injury/Illness ☐ Auto Accident ☐ Other Accident			33. Accident Date - -	34. Accident State
☐ 35. Treatment for Orthodontics	36. Placed Date - -	37. Months Remaining		

Provider Information

I hearby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

Dentist Signature: _____ Date: - -

38. Treating Provider Name (Last, First, M.I., Suffix)			39. Phone
40. Treating Provider Address, City, State, Zip			41. Taxonomy Code
42. Provider NPI# (Type 1)	43. License #/Other ID	44. Provider Billing NPI# (Type 2)	45. License #/Other ID
46. Provider Billing Name (Last, First, M.I., Suffix)		47. Provider Billing SSN/TIN#	48. Phone
49. Provider Billing Address, City, State, Zip			

Services

50. Check missing tooth number(s)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T												

51. Procedure Date	52. Oral Cavity	53. Tooth #/Letter	54. Tooth Surface	55. Diagnostic Codes	56. Procedure Code	57. Treatment	58. Fee
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59. Remarks							**60. Total Fee**