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 622
Minneapolis, MN 55440-0622

PATIENT COVERAGE INFORMATION

1. Patient name — first / m.i. / last
2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other _____
3. Sex — m / f
4. Patient birthdate — MM / DD / YYYY
5. If full time student — school / city
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. or I.D. number
8. Employee/subscriber birthdate — MM / DD / YYYY
9. Employer (company) name and address: **Wells Fargo**
10. Group number: **Enhanced Option 051054**
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 _____

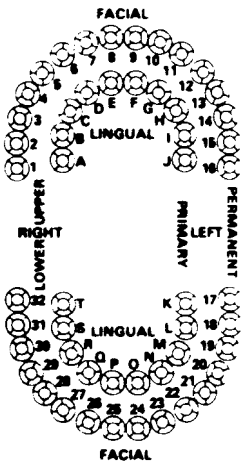
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (Insured person) _____ Date _____

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted
City, State, Zip
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment — Office / Hosp. / ECF / Other
23. Radiographs or models enclosed — No / Yes — How many?
24. Is treatment result of occupational illness or injury? — No / Yes — If yes, enter brief description and dates
25. Is treatment result of auto accident?
26. Other accident?
27. If prosthesis, is this initial placement? — (If no, reason for replacement)
28. Date of prior placement
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 _____ NPI _____ Date _____

Total Fee Charged

Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

See back of ID card for customer service phone number.