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

THIS AREA FOR DELTA USE ONLY

# 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

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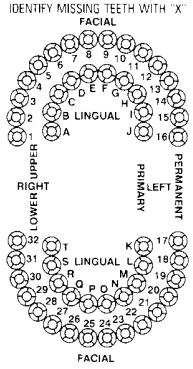
## PATIENT SECTION

| 1. PATIENT NAME (FIRST MIDDLE LAST) | 2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER | 3. SEX M F | 4. PATIENT BIRTHDATE MO. DAY YEAR | 5. IF 19 YEARS OLD AND FULL TIME STUDENT SCHOOL CITY |
|---|---|---|---|---|
| 6. Employee/subscriber name and mailing address | 7. Employee/subscriber soc. sec./ID no. | 8. Employee/subscriber birthday MO. DAY YEAR | 9. Employer (company) name and address | 10. Group Number |
| 11. Is patient covered by another plan of benefits? Dental _____ Medical _____ | 12-a. Name and address of carrier(s) | 12-b. Group no.(s) | 13. Name and address of employer | |
| 14-a. Employee/subscriber name (if different than patient's) | 14-b. Employee/subscriber soc. sec. number | 14-c. Employee/subscriber birthdate MO. DAY YEAR | 15. Relationship to patient ____ self ____ parent ____ spouse ____ other _____ | |

## DENTIST SECTION

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

IDENTIFY MISSING TEETH WITH "X"




31. Examination and Treatment Plan - List in Order from Tooth No. 1 through Tooth No. 32 - Use Charting System shown

| Tooth # or Letter | Surfaces | Description of Service (including X-rays, Prophylaxis, materials used, etc.) LINE NO. | Start Date of Multiple Appointment Procedure MO. DAY YEAR | Completion Date MO. DAY YEAR | For Delta Use Only | Procedure Number | Fee | These Columns For Delta Use Only | POLICY | 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.

33. DENTIST SIGNATURE _____ DATE _____

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.

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

**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)

| | |
|---|---|
| MAXIMUM APPROVED | |
| AMOUNT APPLIED TO DEDUCTIBLE | |
| DELTA PAYS | |
| PATIENT PAYS | |

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 33 34 35 36 37 38

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

DELTA DENTAL®
Northeast Delta Dental

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.