



**Delta Dental of New York, Inc.**  
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**ATTENDING DENTIST'S STATEMENT**

SIGN BELOW FOR PREDETERMINATION \* OR PAYMENT \*\*

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER		3. SEX M F		<b>IMPORTANT</b> 4. PATIENT BIRTHDATE MO. DAY YR.		5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL		CITY	
6. EMPLOYEE/SUBSCRIBER NAME		LAST		FIRST		MIDDLE INITIAL		<b>IMPORTANT</b> 7. SUBSCRIBER I.D. NUMBER		OR 1 _____ OR 2 _____ OR 3 _____ OR 4 _____ OR 5 _____ OR 6 _____	
8. EMPLOYEE HOME ADDRESS		CITY, STATE ZIP		ZIP CODE		9. EMPLOYER (COMPANY) NAME AND ADDRESS  <b>Abilities First Inc.</b>					
10. GROUP NUMBER <b>2296</b>		<b>IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15</b>		11. DELTA - COVERED EMPLOYEE BIRTHDATE MO. DAY YR.		12. SPOUSE NAME		13. SPOUSE BIRTHDATE MO. DAY YR.		15. SPOUSE I.D. NUMBER	
14. NAME AND ADDRESS OF CARRIER											

DENTIST NAME		IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES					
MAILING ADDRESS		IS TREATMENT RESULT OF AUTO ACCIDENT?									
CITY, STATE ZIP		OTHER ACCIDENT?									
DENTIST I.D. NUMBER (NPI)		DENTIST LICENSE		DENTIST PHONE NO.		IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		NO	YES	IF NO, ENTER REASON FOR REPLACEMENT	
FIRST VISIT DATE CURRENT SERIES		PLACE OF TREATMENT OFFICE OTHER		RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/>		HOW MANY? DATE OF PRIOR PLACEMENT		NO	YES	IS TREATMENT FOR ORTHODONTICS?	
IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING											

IDENTIFY MISSING TEETH WITH "X" FACIAL	EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.									
	TOOTH # OR LETTER	SURFACES MOJ DLF	Description Of Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YR.			ADA PROCEDURE NUMBER	FEE		
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* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS  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 _____		TOTAL FEE CHARGED _____  PATIENT PAYS _____  DELTA PAYS _____  AMOUNT APPLIED TO DEDUCTIBLE _____	
** TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.  DENTIST SIGNATURE _____ DATE _____					

FORM DD/NY-0016-04-10