

# FORM WILL BE RETURNED IF INCOMPLETE

MAIL FIRST COPY TO DELTA DENTAL OF ILLINOIS, RETAIN SECOND COPY FOR YOUR FILES. PLEASE TYPE OR PRINT LEGIBLY. STAPLE X-RAYS TO TOP LEFT CORNER OF FORM.

## SPECIALTY REFERRAL FORM DELTA CARE



ALL PATIENT INFORMATION PARTICULARLY THE **BOLD-BLOCKED** AREAS, MUST BE COMPLETED; OTHERWISE, THE FORM WILL BE RETURNED

**Send Form To:** Delta Dental of Illinois  
P.O. Box 3399  
Lisle, IL 60532  
(800) 942-3772

CHECK ONE AND SIGN BELOW  
REQUEST FOR:  
  
PAYMENT  
  
PREDETERMINATION

EMERG. AUTH. #

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE <small>SELF SPOUSE CHILD OTHER</small>	3. SEX <small>M F</small>	4. PATIENT BIRTHDATE <small>MO DAY YEAR</small>	5. IF FULL TIME STUDENT SCHOOL	CITY
6. EMPLOYEE/SUBSCRIBER NAME <small>FIRST MIDDLE LAST</small>	7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NUMBER		9. NAME OF GROUP DENTAL PROGRAM		
8. EMPLOYEE HOME ADDRESS  CITY, STATE, ZIP			10. EMPLOYER (COMPANY) NAME AND ADDRESS		

11. GROUP NUMBER	12. LOCATION (LOCAL)	13. ARE OTHER FAMILY MEMBERS COVERED BY ANY DENTAL INSURANCE? <small>EMPLOYER NAME SOC. SEC. NO.</small>	14. NAME AND ADDRESS OF EMPLOYER, ITEM 13
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15. IS PATIENT COVERED THROUGH ANY ADDITIONAL DENTAL PROGRAM?	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER
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16. DENTIST NAME (NAME OF SPECIALIST TO PERFORM SERVICES)	PAYABLE BENEFITS ARE CONTINGENT UPON PATIENT'S ELIGIBILITY AT THE TIME PROCEDURES ARE COMPLETED. PAYMENT FOR PROCEDURES COMPLETED DURING AN INELIGIBLE PERIOD ARE THE RESPONSIBILITY OF THE PATIENT. ELIGIBILITY IS NOT VERIFIED AT THE TIME OF PREDETERMINATION.
17. MAILING ADDRESS  CITY, STATE, ZIP	
18. DENTIST SOC. SEC. NO OR T.I.N.    19. DENTIST LICENSE NO.    20. DENTIST PHONE NO.	

21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT <small>OFFICE HOSP ECF OTHER</small>	23. RADIOGRAPHS OR MODELS ENCLOSED? <small>NO YES</small>	HOW MANY?	X _____ PATIENT (PARENT OR EMPLOYEE) SIGNATURE	DATE
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IDENTIFY MISSING TEETH WITH "X"    24. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.

	TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE <small>(INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) IF SERVICES LISTED EXCEED 15 LINE ITEMS, PLEASE COMPLETE SEPARATE FORM.</small>	DATE SERVICE COMPLETED			PROCEDURE CODE	FEE
				MO	DAY	YEAR		
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							
	13							
	14							

26. DENTIST NAME (NAME OF REFERRING DENTIST)	<b>SPECIALIST PERFORMING SERVICES</b>  TREATMENT COMPLETED-PAYMENT REQUESTED  THE TREATMENT WAS <u>COMPLETED</u> BY ME AND WAS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PAYMENT IN ACCORDANCE WITH PLAN PARTICIPATING DENTIST RULES.  SPECIALIST SIGNATURE _____ DATE _____
27. MAILING ADDRESS  CITY, STATE, ZIP	