Specialty Referral Form
Delta Care

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

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.

All patient information particularly the bold-blocked areas, must be completed; otherwise, the form will be returned.

1. Patient Name
2. Relationship to Employer
   Self, Spouse, Child, Other
3. Sex
   M, F
4. Patient Birthday
   Day, Month, Year
5. If Full Time Student
   School
6. Employee/Subscriber Name
   First, Middle, Last
7. Employee Subscriber Social Security Number
8. Name of Group Dental Program
10. If Services Listed Exceed 15 Line Items, Please Complete Separate Form.
11. Group Number
12. Location (Local)
13. Are Other Family Members Covered by Any Dental Insurance? Yes, No
   Employer Name
   Soc. Sec. No.
14. Name and Address of Employer, Item 13
15. Is Patient Covered Through Any Additional Dental Plan?
16. Dentist Name
   (Name of Specialist to Perform Services)
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
   Office, Hosp, ECF, Other
23. Radiographs or Models Enclosed?
   How Many?
24. Examination and Treatment Record - List in order from Tooth No. 1 through Tooth No. 32 use charting system shown.
   Identify missing teeth with "X".
   Tooth # or Letter
   Surfaces
   (Including X-rays, prophylaxis, materials used, etc.)
   If Services Listed Exceed 15 Line Items, Please Complete Separate Form.
   Description of Service
   Date Service Completed
   Procedure Code
   Fee

25. Remarks for Unusual Services

26. Dentist Name
   (Name of Referring Dentist)

Specialist Performing Services
Treatment completed, payment requested.
The treatment was completed by me and was necessary in my professional judgment.
I request payment in accordance with plan participating dentist rules.

Specialist Signature

Date

DC-940