DELTA DENTAL®
Delta Dental Plan of Illinois

DELTAUSA®
National Dental Programs

1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

2. Carrier Name and Address
DELTA DENTAL PLAN OF ILLINOIS
P.O. BOX 5402
LISLE, IL 60532

3. Patient name
first m.i. last

4. Relationship to employee
☐ self ☐ child
☐ spouse ☐ other_____

5. Sex
m f

6. Patient birthdate
MM DD YYYY

7. If full time student
school
city

8. Employee/subscriber name and mailing address

9. Employee/subscriber dental plan I.D. number

10. Employee/subscriber birthdate
MM DD YYYY

11. Employer (company) name and address
Argonne National Laboratory
9700 S. Cass Avenue
Argonne, IL 60439

12. Group number
20084

13. Is patient covered by another dental plan ☐ yes ☐ no
If yes, complete 14a
Is patient covered by a medical plan? ☐ yes ☐ no

14a. Name and address of other carrier(s)

14b. Other group no(s)

15. Name and address of other employer(s)

16a. Employee/subscriber name (if different from patient's)

16b. Employee/subscriber birthdate
MM DD YYYY

17. Relationship to patient
☐ self ☐ child
☐ spouse ☐ other_____

18. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
Signed (Parent or guardian) Date

19. I hereby authorize payment directly to the above-name dentist of the group insurance benefits otherwise payable to me.
Signed (Employee/subscriber) Date

20. Name of Billing Dentist or Dental Entity

21. Address

22. City, State, Zip

23. Dentist Soc. Sec. or TIN

24. Dentist license no.

25. Dentist phone no.

26. First visit date current series

27. Place of treatment
Office Hosp ECF Other

28. Radiographs or models enclosed? No Yes How many?

29. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates

30. Is treatment result of auto accident?

31. Other accident?

32. If prosthesis, is this initial placement? (If no, reason for replacement)

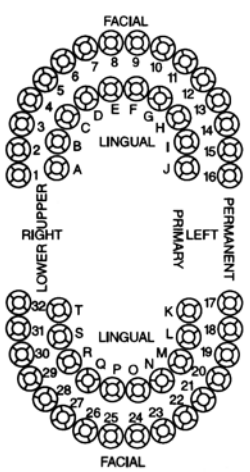
33. Date of prior placement

34. Is treatment for orthodontics? If service already commenced enter

Date appliances placed

Mos treatment remaining

35. Identify missing teeth with "X"



36. Examination and treatment plan - List in order from tooth no 1 through tooth no 32 - Using 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

37. Remarks for unusual services

38. 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 Date

39. Address where treatment was performed
City State Zip

40. Total Fee Charged

42. Payment by other plan

Max. Allowable

Deductible

Carrier %

Carrier pays

Patient pays

DDPI-930 (06/00)