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

THIS AREA FOR DELTA USE ONLY

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

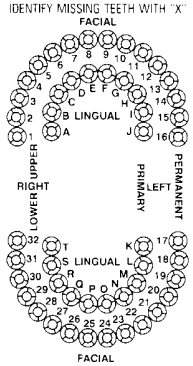
PATIENT SECTION

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

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)

33. DENTIST SIGNATURE _____ DATE _____

**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.