



Claim For Payment
 Claim For Predetermination

Delta Dental of Virginia
 4818 Starkey Road
 Roanoke, VA 24018
 (540)989-8000 or (800)237-6060

EMPLOYEE/SUBSCRIBER MUST COMPLETE SECTIONS 1-17

1. PATIENT NAME		2. RELATIONSHIP TO SUBSCRIBER SELF SPOUSE CHILD OTHER				3. SEX M F	4. PATIENT BIRTHDATE MO. DAY YEAR			5. IF CHILD AGE 19 OR OVER: FULL TIME STUDENT: NO <input type="checkbox"/> YES <input type="checkbox"/> NAME OF SCHOOL	
6. SUBSCRIBER FNAME MI LNAME		7. SUBSCRIBER IDENTIFICATION NO				8. NAME OF EMPLOYER					
10. SUBSCRIBER MAILING ADDRESS						9. GROUP NUMBER					
11. CITY, STATE, ZIP											
12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO <input type="checkbox"/> YES <input type="checkbox"/> IF YES: →		13. EMPLOYEE NAME AND BIRTHDATE				14. SUBSCRIBER ID NO.			15. EMPLOYER NAME		
		16. NAME AND ADDRESS OF CARRIER				17. GROUP NO.					

NAME OF DENTIST OR DENTAL ENTITY Scott H. Leaf, D.D.S.		TAX ID OR SOC. SEC. NO. 27-0773127	IS TREATMENT RESULT OF ACCIDENT? NO <input type="checkbox"/> YES <input type="checkbox"/> IF YES, DATE
MAILING ADDRESS 9316-C Old Keene Mill Road		LICENSE NO. 401005821	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY NO <input type="checkbox"/> YES <input type="checkbox"/> RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/> HOW MANY?
CITY, STATE & ZIP CODE Burke, Virginia 22015		TELEPHONE NO. 703-455-9683	IF PROSTHESIS: IS THIS INITIAL PLACEMENT? NO <input type="checkbox"/> YES <input type="checkbox"/> IF NO, ENTER REASON FOR REPLACEMENT AND DATE OF PLACEMENT IN REMARKS BELOW
			IS TREATMENT FOR ORTHODONTICS? NO <input type="checkbox"/> YES <input type="checkbox"/> IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCE PLACED: MONTHS TREATMENT REMAINING:

DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE	DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE
Periodic Exam				D0120		Extraction				D7140	
Limited Oral Eval				D0140		Extraction				D7140	
Comp Series-BW				D0210		Extraction				D7140	
Periapical 1 st film				D0220							
Periapical EA Add ()				D0230							
1-BW-X-Ray				D0270							
2-BW-X-Ray				D0272							
4-BW-X-Ray				D0274							
Panoramic Film				D0330							
Prophy - Adult				D1110							
Prophy - Child				D1120							
Fluoride - Child				D1203							
Sealant				D1351							
Amalgam 1SF				D2140							
Amalgam 1SF				D2140							
Amalgam 1SF				D2140							
Amalgam 2SF				D2150							
Amalgam 2SF				D2150							
Amalgam 3SF				D2160							
Amalgam 3SF				D2160							
Amalgam 4SF				D2161							
Comp 1SF (Ant)				D2330							
Comp 1SF (Ant)				D2330							
Comp 1SF (Ant)				D2330							
Comp 2SF (Ant)				D2331							
Comp 3SF (Ant)				D2332							
Comp 1SF (Post)				D2391							
Comp 1SF (Post)				D2391							
Comp 1SF (Post)				D2391							
Comp 2SF (Post)				D2392							
Comp 3SF (Post)				D2393							
Pulpotomy				D3220							
RCT-Ant				D3310							
RCT-Bicsp				D3320							
RCT-Molar				D3330							
Perio Scal/Rt Plan				D4341							
Perio Maint				D4910							
TOTAL FEE CHARGED											
ANY SERVICE EXCEEDING \$250.00 SHOULD BE PRE-DETERMINED CLAIM MUST BE FILED WITHIN ONE YEAR OF DATE OF SERVICE											
REMARKS FOR UNUSUAL SERVICES											
						I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY THE TRUTH OF PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD. PATIENT (PARENT OR EMPLOYEE) SIGNATURE x DATE					
						(TREATMENT COMPLETED-PAYMENT REQUESTED)					
						THE TREATMENT LISTED WAS COMPLETED AND WAS NECESSARY IN MY PROFESSIONAL JUDGEMENT. I REQUEST PAYMENT IN ACCORDANCE WITH DDVA PARTICIPATING DENTIST RULES. DENTIST SIGNATURE x DATE					
						(PREDETERMINATION OF COST)					
						THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST AUTHORIZATION IN ACCORDANCE WITH DDVA PARTICIPATING DENTIST RULES. DENTIST SIGNATURE x DATE					