

Delta Dental Plan of Wyoming P.O. Box 29 Cheyenne, WY 82003-0029 For Inquiries Call: WY (307) 632-3313 or (800) 735-3379

## ATTENDING DENTIST'S STATEMENT

Check one:									Carrier name and address									
	Dentist's pre-treatme	nt est	imate															
	Dentist's statement of			ces														
	1. Patient name				2.	Relationship to e	employe	e	3. Se	x 4. F	atient bir	thdate			full time stu	ident		
PAT	first m.i. last					self	m f MM DD YYY											
T I						spouse						city						
EZT	6 Employer/outeralt		mployee/subscriber 8. Employee/s					plave	r (con	mpany) p	ame and ad	dress 10	O. Group	number				
	6. Employee/subscriber name and mailing address								irthdate				припутн	arrio arrio la				
ŏ								M	M DD	YYY	4							
V																		
R																		
COVERAGE	11. Is patient covered by another 12-a. Name and address of					carrier(s)	12-b. Group no.(s)					13. Name and address of other employer(s)						
E	dental plan?																	
N	yes no If yes, complete 12-a.																	
F	Is patient covered by a medical																	
NFORMAT	plan? yes no											15. Relationship to patient						
A	14-a. Employee/subscriber name (if different than patient's)					14-b. Employee/s soc. sec. or			14-c. Employee/subscriber birthdate									
ı i.									MM DD YYYY				self parent spouse otherental benefits otherwise payable to me directly to the					
ON																		
1 ha	ave reviewed the following tr	eatmen	t plan. I aut	thorize rele	ease of	any information	relatin	g to	I hereby a				ne de	ntal ben	efits otherw	vise payable	e to me o	irectly to the
thi	s claim. I understand that I a	m respo	IIISIDIE TOF 8	an costs o	uenta	deadnent.			below Ha	neu uen	an oritity							
7	igned (Patient, or parent if min	or)				Date			Signed	Insured r	person)						Dat	le
- 0	16. Name of Billing Dentist of		Entity			2010									ter brief des	scription and	dates	
В			The State of the								pational or injury?							
L	17. Address where naumont	should i	ne remitted								ment result							
L	17. Address where payment should be remitted							accident?										
N										26. Other a	Olanbian 12	+						
G	City, State, Zip									26. Other a								
D																		
ENT	18. Dentist Soc. Sec. or T.I.N. 19. Dentist license no.					20. Dentist phone	27. If prosthesis, is the initial placement'					(If no, reason for replacement)				28. Date of prior placement		
Ť							Thinks proceed to											
S			treatment osp., ECF	Other	23. Ra	Radiographs or No Yes How r							If services already Date applian commenced placed:		pliances	Mos. treatment remaining		
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											For							
Tooth Surface Description of service										Dat	e ser	rice	Pro	ocedure	Fee	9	administrative use only	
	FACIAL		(including x	k-rays, p	rophylaxis, mater	ed, etc.)			performed Mo. Day Year				number			use only		
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