DELTA DENTAL®

Submit a Claim

If you visit a Delta Dental PPO™ or Delta Dental Premier® dentist, the office will submit a claim directly to Delta Dental of Wisconsin on your behalf. In rare cases or if you choose an out-of-network provider, you may need to submit your own claim to Delta Dental.

How to submit a claim

Step 1 - Fill out the Dental Plan Claim Form on page 2 and attach an Attending Dentist Statement, or have your dentist complete the form.

Step 2 - Log in to your Delta Dental online account at **www.deltadentalwi.com** and click on the "Customer Service" tab. Upload the completed document to the secure message and hit the purple "submit" button. If you do not have an online account, simply register in a few easy steps at **www.deltadentalwi.com** using your Delta Dental subscriber number found on your ID card.

Or, you can also mail your claim form to:
Delta Dental of Wisconsin
PO Box 828
Stevens Point, WI 54481-0828

After your claim has been submitted, you will receive acknowledgment of receipt via secure message within three business days. You may receive a request for additional information if needed to complete the claim processing. Or, if services received require clinical review, additional information may be requested from your provider office. Once all necessary information is received your claim will finalize processing and eligible claim payment will be issued to you or to your provider.

For questions on the status of your claim or claim payments, please contact us at 800-236-3712.

DELTA DENTAL

Delta Dental of Wisconsin

Dental Plan Claim Form

POLICYHOLDER

Policyholder SSN/ID Number ______ Birth Date __/__/__ Gender ______

Policyholder Name (Last, First, M.I., Suffix) ______

Policyholder Address ______

Policyholder City, State, Zip ______

Policyholder Employer ______ Plan/Group Number ______

If I obtain services from a participating dentist (an in-network dentist), I understand that payment of the dental benefits will be sent to the named dentist or dental entity.

Signed: ______ Date: __/__/__

PATIENT

Patient Name (Last, First, M.I., Suffix) ______ Gender ______

Relationship to Policyholder ______ Birth Date __/__/__ Student

I have been informed of the treatment plan and associated fees. I agree to be responsible for charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signed: ______ Date: __/__/__

INSURANCE INFORMATION

Primary Insurance Company ______ Primary Insurance Address, City, State, Zip ______

Primary Insurance Payment ______ Transaction Type: Statement of Service Request for Predetermination/Preauthorization

Secondary Coverage: Yes No If Yes: Dental Medical Name of Policyholder (Last, First, M.I., Suffix) ______

Relationship to Policyholder ______ Birth Date __/__/__ Gender ______ Covered SSN/ID Number ______ Plan Group Number ______

Secondary Insurance Company ______ Secondary Insurance Address, City, State, Zip ______

Predetermination/Preauthorization Number ______

The portion below should be filled out by the dentist who performed the service, or attach the Attending Dentist Statement.

ANCILLARY INFORMATION

Place of Treatment: Provider's Office Hospital

ECF Number of enclosures (0 to 99): Radiograph(s): ____ Oral Image(s): ____ Model(s): ____ Charting: ____

Prosthesis Placed: Initial Placement Prior Placemet Prior Placement Date: __/__/__

Treatment resulting from: Occupational Injury/Illness Auto Accident Other Accident Accident Date: __/__/__ Accident State: ____

Treatment for Orthodontics: Yes No Placed Date: __/__/__ Months Remaining: ____

PROVIDER INFORMATION

I hearby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

Provider Signature: ______ Date: __/__/__

Treating Provider Name (Last, First, M.I., Suffix ______ Phone ______ Treating Provider Address, City, State, Zip ______

Taxonomy Code ______ Provider NPI# (Type 1) ______ License #/Other ID ______ Provider Billing NPI# (Type 2) ______ License #/Other ID ______

Provider Billing Name (Last, First, M.I., Suffix) ______ Provider Billing SSN/TIN# ______ Phone ______

Provider Billing Address, City, State, Zip ______

SERVICES

Check Missing Tooth Number(s)

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
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T												

Procedure Date	Oral Cavity	Tooth Letter	Tooth Surface	Diagnostic Codes	Procedure Code	Treatment	Fee
/ /							
/ /							
/ /							
/ /							
Remarks							Total Fee: