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 on your behalf.

Electronic claims may be submitted to Payer ID: WDENC

In rare cases or if you choose an out-of-network dentist, you may need to submit your own claim to Delta Dental. To submit a claim, fill out the Dental Plan Claim Form on page 2 and attach an Attending Dentist Statement, or have your dentist complete the form.

Mail directly to:
Delta Dental
PO Box 103
Stevens Point, WI 54481-0103

DELTA DENTAL

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: