



## Dental Benefits – Claim Instructions

**NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, DELTA DENTAL ENCOURAGES DENTAL OFFICES TO SUBMIT YOUR CLAIMS ELECTRONICALLY.**

### TO THE EMPLOYEE

1. Complete items one (1) through ten (10) in full.
2. Complete items 11 – 15 only if other dental coverage exists.
3. Patient or Parent signature is required for payment and to release any information relating to this claim. The signature area is located below boxes 14-a-14-b.
4. Payment goes directly to all participating providers. If services are rendered by a non-participating provider, payment will be made directly to you the subscriber.

If total charges for the planned course of treatment are expected to exceed the minimum Predetermination dollar amount stated in your dental plan booklet, it is suggested you file for Predetermination of Benefits. Delta Dental will notify your dentist of the benefits payable.

**NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR DENTAL BOOKLET FOR DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND COPAYMENT INFORMATION, AND LIMITATIONS AND EXCLUSIONS.**

### TO THE DENTIST

1. **COMPLETED SERVICES** — Complete items 16 through 30. When entering the treatment plan on the form, please indicate a separate fee for each individual service rendered.
2. **PREDETERMINATION OF BENEFITS** — If total charges for this claim are to exceed \$500.00 Predetermination of Benefits is suggested. Complete items 16 through 30.
3. Treating dentist must sign the claim form at the bottom located below box 31.

**NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE EMPLOYEE, DENTIST AND INSURANCE COMPANY CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.**

**\*X-rays taken for major services should be submitted with treatment plan. X-rays will be reviewed by practicing Dentists and returned promptly provided they are properly labeled.**

### TO THE EMPLOYEE & DENTIST

Send the completed benefits request and the bills to: **Delta Dental of South Dakota  
PO Box 1157  
Pierre, SD 57501**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.