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

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

2. Submit your claim form and Attending Dentist Statement to Delta Dental of Wisconsin.

FOR INDIVIDUAL SUBSCRIBERS

Your subscriber number found on your ID card starts with "077" or "08".

MAIL TO:
Delta Dental of Wisconsin
PO Box 103
Stevens Point, WI 54481-0103

QUESTIONS:
To check on the status of your claim or claim payments, call 888-899-3734.

FOR MEMBERS WITH COVERAGE THROUGH AN EMPLOYER

MAIL TO:
Delta Dental of Wisconsin
PO Box 828
Stevens Point, WI 54481-0828

OR SEND A SECURE MESSAGE:
- Log in to, or register for, your online account at **deltadentalwi.com**
- Click on the "Customer Service" tab
- Upload the completed claim form to a new secure message
- Submit your secure message – an acknowledgment of receipt will be sent via secure message within three business days

QUESTIONS:
To check on the status of your claim or claim payments, call 800-236-3712.

3. Once all necessary information* is received, your claim will processing finalize and eligible claim payment will be issued to you or to your provider.

*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.

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

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly 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 | Payer ID

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 | Other Payer ID

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: ____ Date of Last SRP: _____

Prosthesis Placed: ☐ Initial Placement ☐ Prior Placement 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 hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

Provider Signature: _____ Date: _____ Locum Tenens Treating Dentist? ☐ Yes ☐ No

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: