DELTA DENTAL®

Date _____

Call Delta Dental of Kentucky
1-800-955-2030

DASI ASSIST

For dental office internal use only. This matches the order of DASI's responses; just fill in the blanks or check the correct answer. Remember, say "repeat" at any time and DASI will start that section over.

The eligibility and benefits are based on the information Delta Dental has available on the date of this request and are not a guarantee of payment. Estimated patient out-of-pocket expenses can be determined prior to treatment by the submission of a predetermination.

HAVE THIS INFORMATION READY WHEN YOU CALL:

Dentist's Tax ID Number: _____ Member's SSN/ID number: _____

Patient's name: _____ Relationship to member: ❑ subscriber ❑ spouse ❑ dependent

Patient's date of birth: _____

ELIGIBILITY INFORMATION

Eligible: ❑ yes ❑ no

Program enrolled in: ❑ Delta Dental Premier ❑ Delta Dental PPO

❑ Other _____

Group-subgroup number: _____ **Current effective date**: _____

Based on the patient's current dental history, if the following services were rendered today, the following services would be allowed/would not be allowed, provided maximum is available:

Exam	❑ yes	❑ no	**Cleaning**	❑ yes	❑ no	**Perio Maintenance Cleaning**	❑ yes	❑ no
BWX	❑ yes	❑ no	**FMX**	❑ yes	❑ no	**Fluoride**	❑ yes	❑ no
						Occlusal Guard	❑ yes	❑ no

Group-specific eligibility message (if any) _____

BENEFIT INFORMATION

Group Specific Benefit message (if any) _____

Does the dentist participate in the member's program? ❑ yes ❑ no

		Benefit %	**Waiting Period**	**Time Limitations and Exclusions**
Diagnostic		_____	_____	_____
	Exams	_____	_____	_____
Preventive		_____	_____	_____
	Cleanings	_____	_____	_____
	Space maintainers	_____	_____	_____
	Fluoride treatments	_____	_____	_____
	Enhanced Preventive Benefits	_____	_____	_____

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	Benefit %	Waiting Period	Time Limitation and Exclusions
Brush Biopsy	_____	_____	_____
Sealants	_____	_____	1st molars to age _____, 2nd molars to age _____ limited to once per tooth per _____ Other _____
Bitewing Radiographs	_____	_____	Payable _____ per _____
Radiographs	_____	_____	_____
FMX	_____	_____	Payable _____ per _____
Filling Restorations	_____	_____	_____
Posterior Composites	_____	_____	Optioned to amalgam? ❑ yes ❑ no
Single Crowns/Crown Build Ups	_____	_____	_____ per tooth in _____ months
Endodontics	_____	_____	_____
Periodontics	_____	_____	_____
Occlusal Guard	_____	_____	Payable _____ in a lifetime
Root Planning and Scaling	_____	_____	Payable _____ per quadrant in _____ months
Fixed Bridges, Partials and Dentures	_____	_____	_____ Month replacement limit
Missing Tooth	_____	_____	_____
Denture Repairs	_____	_____	_____
Implants	_____	_____	_____
Simple Extractions	_____	_____	_____
Other Oral Surgery	_____	_____	_____
TMD	_____	_____	_____
Orthodontics	_____	_____	Covered to age _____ and Adult Orthodontics ? ❑ yes ❑ no

Group Specific Message (if any) _____

Delta Dental pays for crowns, bridges, full and partial dentures based on the delivery date of the permanent appliance.

MAXIMUM AND DEDUCTIBLE INFORMATION

Group specific maximum message (if any) _____

Benefit year begins _____ **Benefit year ends** _____

Deductibles (if any)	**Amount**	**Met to date**	**Does not apply to**
Individual benefit period	$_____	$_____	_____
Individual lifetime	$_____	$_____	_____
Individual orthodontic	$_____	$_____	_____
Family benefit period	$_____	$_____	_____
Family lifetime	$_____	$_____	_____

Maximums	**Amount**	**Used to date**	**Procedures that do not apply**
Individual benefit period	$_____	$_____	_____
Individual lifetime orthodontic	$_____	$_____	_____
Individual _____ maximum	$_____	$_____	_____
Family program	$_____	$_____	_____
Family lifetime	$_____	$_____	_____

Deductible ❑ yes ❑ no

COORDINATION OF BENEFITS

Internal (within the same client): Coordination of benefits ❑ is ❑ is not allowed when the other member is covered within this client.

External (with another carrier or Delta Dental client): Coordination of benefits ❑ is ❑ is not allowed when the member is covered with another dental plan.

External non-duplication clause (carve-out): This client contract contains a non-duplication of benefits clause for co-ordination of benefits when the other member is covered with another dental plan. ❑ yes ❑ no

Children only: Internal and external coordination of benefits allowed for dependent children only. ❑ yes ❑ no

Other: _____

Coordination of Benefits Information is based on what is submitted on a claim.

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