



Pre-Estimate

P.O. Box 9695
 BOSTON MASSACHUSETTS 02114-9695
 CUSTOMER SERVICE (617) 886-1234
 MSEU CUSTOMER SERVICE
 CORPORATE OFFICE (617) 886-1000
 FAX (617) 886-1199
 INTERNET www.deltadentalma.com

Toll Free (800) 872-0500
 Toll Free (800) 553-6277
 Toll Free (800) 451 1249

RETURN THIS FORM AS THE CLAIM FORM

BEFORE RETURNING, PLEASE BE SURE TO
 1. INSERT THE DATE OF SERVICE (COMPLETION DATE) FOR THE TREATMENT COMPLETED
 2. DRAW A LINE THROUGH A SERVICE NOT PERFORMED

Phil Fillings, DDS
 123 Pleasant Street
 Anytown, MA 12345

DATE OF ISSUE: mm/dd/yyyy
 PATIENT: Sally Smiles
 RELATIONSHIP: Self
 DATE OF BIRTH: mm/dd/yyyy

SAMPLE

DENTIST: Phil Fillings, DDS
 DENTIST NO: xxxxxxxxx
 PAY CODE:
 COB:

PRE-ESTIMATE NO: xxxxxxxxxxxx
 SUBSCRIBER ID: xxxxxxxxx
 GROUP NO: xxxxxx-xxxx
 GROUP NAME: No Cavities, Inc.
 PRODUCT: Delta Premier

SUBSCRIBERS ARE ENTITLED TO A FULL AND FAIR REVIEW OF THEIR CLAIM, SUBSCRIBERS WHO WRITE SHOULD INCLUDE SUBSCRIBER ID, PRE-ESTIMATE NUMBER NOTED ON THIS FORM AND TELEPHONE NUMBER. LETTERS WILL BE ANSWERED WITHIN 180 DAYS OF RECEIPT OF YOUR REQUEST

TOOTH NO. OR LETTER	TOOTH SURFACE	DATE OF SERVICE MM/DD/YY	PROCEDURE CODE	PROCEDURE DESCRIPTION							
				DENTIST'S CHARGE	CONTRACT ALLOWANCE	DEDUCTIBLE	INSURANCE % COPAY	ESTIMATED PATIENT PAYMENT	ESTIMATED INSURANCE PAYMENT	POLICY CODE	
			8670	PERIODIC TREATMENT VISIT	270.00	270.00	0.00	50	135.00	128.25	
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ESTIMATED PAYMENTS HAVE NOT BEEN APPLIED TO THE REMAINING BENEFITS LISTED BELOW:

BENEFITS ARE SUBJECT TO ANNUAL MAXIMUM: \$ 2,000.00
BENEFITS UTILIZED YEAR-TO-DATE: \$ 0.00
***REMAINING BENEFITS FOR CALENDAR/PLAN YEAR:** \$2,000.00
LIFETIME ORTHODONTIC MAXIMUM: \$1,500.00

DEFINITIONS

CONTRACT ALLOWANCE: Amount used to calculate Delta's portion of payment.
 DEDUCTIBLE: Amount patient must pay for covered services before dental plan begins to pay.
 ESTIMATED PATIENT PAYMENT: Amount payable by the patient to the dentist. It consists of deductible, and non-covered items.

PRE-ESTIMATES ARE NOT A GUARANTEE OF PAYMENT

BENEFITS ARE CALCULATED BASED ON CURRENT AVAILABLE BENEFITS AND PATIENT ELIGIBILITY. ESTIMATES ARE SUBJECT TO MODIFICATION BASED ON ELIGIBILITY, COORDINATION OF BENEFITS, AND THE BENEFIT PLAN IN EFFECT AT THE TIME SERVICES ARE COMPLETED.

*REMAINING BENEFITS WILL BE REDUCED BASED ON CLAIMS PAID AFTER DATE OF ISSUE OF THIS FORM.

 DENTIST DATE



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SAMPLE

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			8670	PERIODIC TREATMENT VISIT	270.00	270.00	0.00	50	185.50	84.50	902

POLICY CODE EXPLANATION:

902 =====>THE LIFETIME MAXIMUM BENEFIT PROVISIONS OF YOUR CONTRACT HAS BEEN REACHED.

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I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY THE DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE USUAL FEES I CHARGE AND INTEND TO COLLECT FOR THOSE PROCEDURES. I REQUEST PAYMENT IN ACCORDANCE WITH DELTA DENTAL PLAN OF MASSACHUSETTS RULES AND REGULATIONS.

 DENTIST

 DATE

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