DELTA DENTAL®

Date: _____

DASI ASSIST FORM

1-800-223-3104

For dental office internal use only. This form matches the order of DASI's responses; just fill in the blanks or circle 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 Identification 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**: Premier PPO

Group/Subgroup Number: _____

Based on the patient's current dental history, if the following services were rendered today, the (exam, cleaning, bitewing X-rays, full mouth X-rays) would be allowed, provided maximum is available:

Exam: yes no **Cleaning**: yes no
BWX: yes no **FMX**: yes no

Group-specific eligibility message (if any): _____

Does the dentist participate in the member's program? yes no
Waiting period (if any): _____

BENEFIT INFORMATION

		Benefit %	Routine Time Limitations
Preventive		_____	_____
	Exams	_____	_____
	Cleanings	_____	_____
	Fluoride	_____	_____
Radiographs		_____	_____
	FMX	_____	_____
	BWX	_____	_____
Sealants		_____	1st molars to age _____ 2nd molars to age _____
			limited to one per tooth per _____
			Other _____
Endodontics		_____	
Periodontics		_____	Root planing/scaling payable ___ per quadrant in ___ months
			Occlusal guard payable _____

	Benefit %	Routine Time Limitations
Oral Surgery	_____	_____
Filling/Restoration	_____	_____
Single crown/crown build-up	_____	_____ per tooth in _____ months
Fixed Bridges, partial and full dentures	_____	_____ month replacement limit
Denture repairs	_____	_____
Orthodontics	_____	covered to age _____ adult orthodontics: yes no

Group specific benefit message (if any) _____

MAXIMUM AND DEDUCTIBLE INFORMATION

Group specific maximum message (if any): _____

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

Deductibles	**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 group): Coordination of benefits **is/is not** allowed when the other member is covered within this group.

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

External non-duplication clause (carve-out): This group contract contains a non-duplication of benefits clause for coordination of benefits when the other member is covered with a dental plan **yes** **no**

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

Other: _____