



P.O. Box 7736
San Francisco, California 94120-7736

DELTA USE ONLY

Delta Dental Plan of California

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

Form sections 1-30 containing patient and employee information, including names, addresses, birthdates, and social security numbers.

Table with columns: ITEM, AUTH - AD CODE, PMT - AD CODE, CR CODE, DF, CC, ELIG CODE, CLM POL, PRO #, and amount.

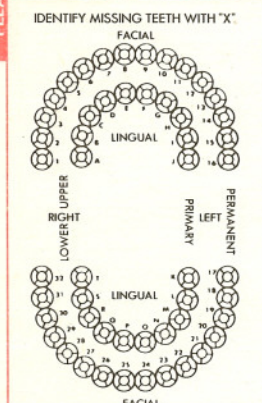


Table for 31. EXAMINATION AND TREATMENT RECORD with columns for TOOTH NO. OR LETTER, SUR-FACES, DESCRIPTION OF SERVICE, DATE SERVICE PERFORMED, D, PROCEDURE NUMBER, FEE, APP., ALW., and ADJ.

Form sections 32-33 containing patient signature, dentist signature, and financial summary including total fee charged and amount applied to deductible.

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

ATTENDING DENTIST'S STATEMENT
DELTA 105 Rev. 2/95

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1. SUBMIT TO DELTA
2. RETAIN FOR YOUR FILES

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