My dentist may give Delta Dental and any other carrier named above information about my dental condition or treatment needed to determine benefits for up to 5 years from the date.

Signature of patient (or parent or guardian) ___________________________ Date __________________

You may receive a copy of this authorization on request.

**PRE-TREATMENT ESTIMATE**

The treatment listed is necessary in my professional judgement, and I request a pre-treatment estimate.

Dentist Signature ___________________________ Date __________________

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**TREATMENT COMPLETED – PAYMENT REQUESTED**

The treatment listed was completed. I will charge and intend to collect the entire portion of the fees stated above that Delta Dental determines to be the patient’s responsibility, and I will not waive, reduce or rebate any of that portion unless I expressly state on this form.

Dentist Signature ___________________________ Date __________________

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**TOTAL FEE CHARGED**

**PATIENT PAYS**

**DELTA DENTAL PAYS**

**AMOUNT APPLIED TO DEDUCTIBLE**