

## Delta Dental Claim Form

It is generally best to have your dentist submit/resubmit claims. If you wish to do so individually, you may mail this form, along with the receipt/statement from the provider, to:

Delta Dental Plan of Michigan  
Customer Service  
P.O. Box 9085  
Farmington Hills, MI 48333-9085

Today's Date: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_ Group Number: 8330

Subscriber's Birth Date: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_

Patient's Birth Date: \_\_\_\_\_

Patient's Relationship to Subscriber (child, spouse, etc.): \_\_\_\_\_

Best Phone Number to Contact with Questions: \_\_\_\_\_

Dentist's Name and Phone Number: \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

Date of Services: \_\_\_\_\_

Description of Services: \_\_\_\_\_

Any Other Notes: