DELTA DENTAL® Delta Dental of Washington

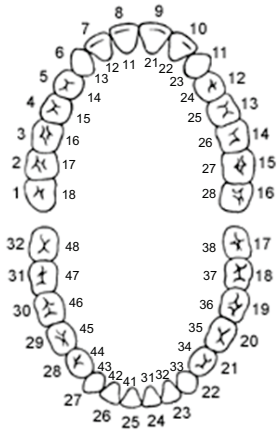
OUT OF COUNTRY CLAIM

Employee/Subscriber Name:		
Mailing Address:		Telephone Number:
City:	State, Zip Code, Country:	Email Address:
Date of Birth (MM/DD/CCYY):	Subscriber ID Number:	Group/Plan Number:
Patient Name:	Date of Birth (MM/DD/CCYY):	Relationship to Employee: Self ☐ Spouse ☐ Child ☐ Other ☐

Complete this section if patient is covered by another dental plan:

Other Insured's Name:	ID Number:	Date of Birth:	Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐
Name and Address of Other Carrier:			Group Number:
Dental services received in (country):		LIC #: **OOC - PR**	Charges submitted in (currency):

A receipt is required for processing however, to expedite processing and payment please attach any supporting documentation, name and address of dental care provider, itemizations of services rendered, tooth numbers and surfaces, date of service and charges. All submitted charges will be converted to US dollars upon processing.



Tooth # or Letter	Surface	Proc Code (DDWA Only)	Description	Mo	Day	Yr	Charges (DDWA will convert)
						Total:	

Special Instructions / Requests:

Out of Country Claims may be submitted:
Fax: 509.685.6599 | Email: outofcountry@deltadentalwa.com | or mail: Delta Dental of Washington PO Box 75688 Seattle, WA 98175
www.DeltaDentalWA.com Telephone: 800.554.1907