



Date \_\_\_\_\_

Call Delta Dental of Kentucky  
1-800-955-2030

# DASI ASSIST

For dental office internal use only. This matches the order of DASI's responses; just fill in the blanks or check 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 ID 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:  Delta Dental Premier  Delta Dental PPO

Other \_\_\_\_\_

Group-subgroup number: \_\_\_\_\_ Current effective date: \_\_\_\_\_

Based on the patient's current dental history, if the following services were rendered today, the following services would be allowed/would not be allowed, provided maximum is available:

Exam  yes  no      Cleaning  yes  no      Perio Maintenance Cleaning  yes  no  
BWV  yes  no      FMX  yes  no      Fluoride  yes  no  
Occlusal Guard  yes  no

Group-specific eligibility message (if any) \_\_\_\_\_

## BENEFIT INFORMATION

Group Specific Benefit message (if any) \_\_\_\_\_

Does the dentist participate in the member's program?  yes  no

	Benefit %	Waiting Period	Time Limitations and Exclusions
<b>Diagnostic</b>	_____	_____	_____
Exams	_____	_____	_____
<b>Preventive</b>	_____	_____	_____
Cleanings	_____	_____	_____
Space maintainers	_____	_____	_____
Fluoride treatments	_____	_____	_____
Enhanced Preventive Benefits	_____	_____	_____

This may be duplicated for dental office use.



**MAXIMUM ANNUAL DEDUCTIBLE INFORMATION**

Group specific maximum message (if any) \_\_\_\_\_

Benefit year begins \_\_\_\_\_ Benefit year ends \_\_\_\_\_

Deductibles (if any)	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 client): Coordination of benefits  is  is not allowed when the other member is covered within this client.

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

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

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

**Other:** \_\_\_\_\_

**Coordination of Benefits Information is based on what is submitted on a claim.**

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