DELTA DENTAL

Application for Extended Dependent Dental Plan Eligibility

Delta Dental of New Mexico

Note: Delta Dental of New Mexico can accept a Social Security disability award letter in place of Part 2 of this form (attending physician's documentation). The award letter must state on which date the dependent became disabled and whether it is a temporary or permanent disability.

Part 1 - To Be Completed by Employee or Primary Plan Participant and/or Authorized Representative

Name of Employee or Primary Plan Participant: ____________________

Social Security No. or Dental Plan ID #: ____________________

Dependent's Name: ____________________ Dependent's DOB: ____________________

As an Authorized Representative (parent, guardian, etc.), I authorize release of all medical information on the above named dependent, including medical history, diagnosis, prognosis, and treatment of any physical or mental condition.

Name (Please Print): ____________________ Relationship to Dependent: ____________________

Signature: ____________________ Date Signed: ____________________

Part 2 - To Be Completed by Dependent's Attending Physician

Primary diagnosis: ____________________

Other related diagnosis: ____________________

Date patient first consulted you for these conditions: ____________________

Date of most recent visit: ____________________

Describe the patient's physical, mental, and cognitive limitations and work/activity limitations:

____

____

Is the patient totally disabled? ☐ Yes ☐ No

Please provide the date the patient became totally disabled: ____________________

When do you expect a fundamental or marked change in patient's condition?

Check One: ☐ Never ☐ Condition Expected to Regress ☐ Condition Expected to Improve

If applicable, anticipated date of recovery: ____________________

Or, unable to determine: Follow up in ____________________ months.

Remarks: ____________________

____

Physician's Signature:____ Date: ____________________

Physician's Name (Please Print): ____

Physician's Address:____

Physician's Phone Number: ____

Part 3 - To Be Completed by the Person Submitting this Form

Signature of the Person Submitting this Form:____

Name of the Person Submitting this Form (Please Print): ____________________________________

Date: ____________________________________

Return this Form to:

Delta Dental of New Mexico
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109

Telephone: (505) 883-4777
Toll-Free: (800) 999-0963
Fax: (505) 883-7444