DELTA DENTAL®

Healthy { benefits smile you }

Self-Report Form

As a member of Delta Dental of Kansas' (DDKS) **Healthy Benefits, Healthy Smile, Healthy You** program, you qualify for additional dental cleanings, covered as preventive care, if you have certain medical conditions. Fill out this form in order to take advantage of two additional dental/periodontal cleanings in a benefit period.

Patient Name: _____

Employer: _____

Home Address: _____

City, State, ZIP: _____

Delta Dental Subscriber ID# *(Social Security Number or Member ID Number)*: _____

Please indicate which of the following medical conditions you are experiencing. Check all that apply. Upon receipt of this form, you will be eligible for two additional cleanings.

Note: *You are also eligible for extra cleanings if you are diagnosed with periodontal disease. Your dentist will have a record of your treatment for periodontal disease on file. You may complete this form or your dentist may complete it for you.*

_____ **Diabetes**

_____ **Kidney failure or undergoing dialysis**

_____ **Periodontal disease**

_____ **Pregnancy** Estimated Due Date: _____/_____/_____
Coverage for additional cleanings will end 30 days following the estimated due date.

_____ **Suppressed immune system** *(caused by radiation treatment, chemotherapy, HIV infection, stem cell or bone marrow transplant or an organ transplant)*

By indicating a condition, I verify that Delta Dental of Kansas reserves the right to obtain information from my treating dentist to confirm the medical condition provided.

Signature: _____ **Date:** _____
(Patient or dentist may sign)

Upon completion, return the self-report form by fax, email or mail:

Mail: Delta Dental of Kansas
Attn: Eligibility
P.O. Box 789769
Wichita, KS 67278-9769

Fax: (316) 462-3394
Email: eligibility@deltadentalks.com