DELTA DENTAL

Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002

Dependent Verification Request

To:

Group:
Date:
Subscriber ID:

We are in receipt of a claim for your dependent noted below. In order to determine coverage for your dependent, and to ensure timely processing of the claim, we would appreciate your completing this form and promptly returning it. If you are unable to respond within 21 days, we will assume the coverage for this dependent should be canceled and the claim(s) denied.

Dependent's Name: Birth Date:

1. **Is the dependent a student in an accredited school, college, or university?** **Yes** ☐ **No** ☐

   If yes:

   Name of the School: _____

   Current school year: _____ to _____

   If no:

   Is the dependent incapacitated? ☐ **Yes** ☐ **No**

2. **If the dependent is incapacitated, we must receive written verification from the attending physician on his/her letterhead, which must include the following information:**

   A) Type of disability
   B) Prognosis – permanent or temporary
   C) If temporarily disabled, expected duration

Upon the return of this form to our office, the claim will be processed promptly, and our records will be changed to reflect the dependent's status as verified by you and/or the attending physician. Students will be updated for the current school year. Please remember to notify your employer if coverage for this dependent has changed.

If you have any questions, please feel free to contact our Customer Service department at 603-223-1234 or 800-832-5700.

I hereby affirm that, to the best of my knowledge and belief, the information provided in this document is true and accurate.

SUBSCRIBER'S SIGNATURE _____ Date _____

Subscriber's daytime telephone number: _____

This form is to be completed by the subscriber and returned to Northeast Delta Dental