



# Healthy Smiles, Healthy Lives<sup>®</sup>

## Self-Report Form

Dear Healthy Smiles, Healthy Lives Benefit Recipient:

Welcome to Healthy Smiles, Healthy Lives Benefits. This confidential form, when submitted to Delta Dental, will enable you to take advantage of extra dental and/or periodontal cleanings (up to a total of 4 annually) when you have certain medical conditions. Please indicate below which of the following medical conditions you are experiencing. Check all that apply.

**Note: If you have already received periodontal therapy and claims for those services are on file with Delta Dental, you do not need to file a self-report form. Your benefits have already been updated to provide coverage for the additional cleanings/periodontal maintenance visits.**

Please note that you may complete this form or your dentist may complete it for you.

- Diabetes
- Kidney failure or undergoing dialysis
- Periodontal disease
- Pregnancy - Please provide estimated due date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Suppressed Immune System

(A suppressed immune system enables coverage when caused by one of the following: radiation treatment, chemotherapy, HIV infection, stem cell or bone marrow transplant or an organ transplant).

Patient name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Patient employer: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Patient home address: \_\_\_\_\_ Subscriber ID\* #: \_\_\_\_\_  
(\*Employee's SSN or Alternate ID Number)

*I verify this is accurate and agree that Delta Dental may verify this information as recorded on the health history records retained by the attending dentist.*

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(The person filing the report should sign. The dentist should sign if they are filing for the patient)

Dentist Tax ID or License Number: \_\_\_\_\_  
(Only necessary when the dentist is filing for the patient)

Now that you have completed your self-report of a medical condition that enables extra dental and/or periodontal cleanings, you can submit this to Delta Dental by mail, by fax or by email. If you are mailing your form, please mail it to:

Delta Dental of Missouri  
Attn: Customer Service  
PO Box 8690  
St. Louis, MO 63126-0690

You may also email it to  
[HealthySmiles@DeltaDentalMO.com](mailto:HealthySmiles@DeltaDentalMO.com)  
or fax it to 314-656-2900.  
Questions, please call us at: 1-800-335-8266.