



Member Attestation Form Integrated Oral Health Option

The Integrated Oral Health Option (IOH) provides up to two additional dental cleanings or periodontal maintenance procedures (in any combination) per benefit period for members and dependents who have been diagnosed with one of the below conditions. **Your employer or group must offer IOH to be eligible for these extra benefits.**

Member information:

Member name:	Member ID number:
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Qualifying health condition:

diabetes dry mouth related to autoimmune diseases, medications, or menopause

cardiovascular disease COPD head and neck cancers

kidney disease lupus pregnancy (expected due date:)

Physician information:

Please provide contact information for the physician currently treating you for the selected condition.

Physician name:	Physician phone number:	Physician address:
Physician email:		

Patient attestation and authorization:

I attest that the information provided regarding my medical condition is accurate and truthful for the purpose of obtaining the Integrated Oral Health Option.

I authorize the physician listed above to release health information relevant to the condition indicated to Delta Dental of New Jersey and/or Delta Dental of Connecticut solely for the purpose of benefit verification. I understand that Delta Dental of New Jersey and/or Delta Dental of Connecticut may contact my physician to verify this information

I agree to promptly notify Delta Dental of New Jersey and/or Delta Dental of Connecticut if I no longer have the condition to which I am currently attesting.

Signature	Date
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Once completed, please return to Delta Dental.

Mail:	Fax:
Delta Dental of New Jersey	973-944-4543
P.O. 16354	
Little Rock, AR 72231	

Questions?

Please call Customer Service at **800-452-9310**.
Monday - Thursday, 8:00 a.m. – 6:30 p.m. ET
Friday 8:00 a.m. – 5:00 p.m. ET