DELTA DENTAL

Delta Dental of New Jersey, Inc.
Certification of Handicapped Child's Dependency Status

Instructions for Completion:

1. Member: Please complete the information listed below and present this form to your child's physician.
2. Physician: Please complete and sign the Physician's Statement below.

Member's Name: _____
Member's ID Number: _____
Member's Group Number: _____
Dependent's Name: _____
Dependent's Date of Birth (Month/Day/Year) _____

Physician's Statement

I herby certify that _____ is
(Dependent's Name)

incapable of self support, due to the following condition (please list specific diagnosis):

_____

_____

_____

_____ Date: _____
Physician's Signature

Please mail or fax this form to:

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, New Jersey 07054
Attention: Customer Service Department

Fax Number: 973-285-4141