



**Delta Dental of New Jersey, Inc.**  
**Oral Health Enhancement Option - Qualification Form**

**INDIVIDUALS TREATED FOR PERIODONTAL (GUM) DISEASE**

Oral health is one important factor in managing your overall health. Scientific findings have shown an association between the presence of oral disease and serious chronic medical conditions. While the science is still emerging, there is general agreement that unchecked oral disease can adversely impact overall health.

Your dental plan administered by Delta Dental of New Jersey, Inc. offers the *Oral Health Enhancement Option*, which enables eligible enrollees who have been treated for periodontal (gum) disease to receive up to two additional dental cleanings and/or periodontal maintenance procedures in any combination per benefit period beyond your plan's ordinary limit. **This benefit is an option offered to employers. Your employer must have elected this feature for you to qualify.**

To qualify for the *Oral Health Enhancement Option*, you must provide proof of having received periodontal surgery or periodontal scaling & root planing. You can do this in one of three ways:

- 1) Send a copy of an explanation of benefits from a prior insurance carrier that clearly shows the most recent date(s) that you received either periodontal surgery or periodontal scaling & root planing;
- 2) Send a copy of a bill from the treating dentist that clearly shows the most recent date(s) that you received either periodontal surgery or periodontal scaling & root planing;
- 3) Have your dentist complete the form below and fax, mail or e-mail the form to:

Delta Dental of New Jersey, Inc.  
P.O. Box 222  
Parsippany, New Jersey 07054  
Fax: (973) 285-4141 E-Mail: [service@deltadentalnj.com](mailto:service@deltadentalnj.com)

You will be enrolled in the *Oral Health Enhancement Option* once your complete form and documentation is received by Delta Dental of New Jersey. Note: If you receive periodontal surgery or periodontal scaling & root planing after you are covered by Delta Dental of New Jersey, you will be automatically enrolled once your claim for these services has been processed. Questions? Call Customer Service at 1-800-452-9310.

**Oral Health Enhancement Option Enrollment Form**

Enrollee Name: \_\_\_\_\_

Member Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Group ID Number: \_\_\_\_\_

Group Name: \_\_\_\_\_

Documentation Provided (check one):

Explanation of Benefits from Prior Carrier  Bill from Treating Dentist  Confirmation from Dentist (completed below)

Dentist Name: \_\_\_\_\_ Dentist License Number: \_\_\_\_\_ State: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_

Services Received (check all appropriate):

Periodontal Surgery  If checked provide most recent date service provided: \_\_\_\_\_

Periodontal Scaling & Root Planing  If checked, provide most recent date service provided: \_\_\_\_\_