DELTA DENTAL Delta Dental of Washington

Disabled Dependent Verification

Group Name: _____

Group Number: _____

Subscriber Name: _____

Subscriber ID: _____

Patient Name: _____

Patient DOB: _____

Claims will not be paid on a dependent until DDWA receives documentation, (such as a physician statement), verifying the disability and the duration.

Please fax this letter, along with your documentation, to 509-685-6768. Or mail to:

Delta Dental of Washington
PO Box 75688
Seattle, WA 98175-0688