Horizon Blue Cross Blue Shield of New Jersey

Reset Form

ATTENDING DENTIST'S STATEMENT

Check one:
☐ **Dentist's pre-treatment estimate**
☐ **Dentist's statement of actual services**

Carrier name and address:

Horizon Blue Cross Blue Shield of New Jersey
Dental Programs
PO Box 1311
Minneapolis, MN 55440-1311

PATIENT COVERAGE INFORMATION

1. Patient name (first / m.i. / last)	2. Relationship to employee	3. Sex	4. Patient birth date	5. Full time student
	☐ self ☐ child ☐ spouse ☐ other _____	M F	MM DD YYYY	☐ yes ☐ no If yes: School / City

6. Employee/subscriber name & mailing address	7. Employee/subscriber soc sec or I.D. number	8. Employee/subscriber birth date	9. Employer (company) name and address	10. Group number
		MM DD YYYY		

11. Is patient covered by another dental plan?	12-a. Name and address of carrier(s)	12-b. Group No.(s)	13. Name and address of other employer(s)
☐ yes ☐ no If yes, complete 12-a Is patient covered by a medical plan? ☐ yes ☐ no			

14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. number	14 c. Employee/subscriber birth date	15. Relationship to patient
		MM DD YYYY	☐ self ☐ parent ☐ spouse ☐ other

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

► _____
Signed (insured person) **Date**

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

► _____ _____
Signed (insured person) **Date**

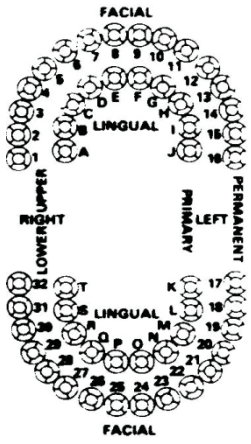
BILLING DENTIST

16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
17. Address where payment should be remitted	25. Is treatment result of auto accident?			
City, State, Zip	26. Other accident?			

18. Dentist Soc Sec or T.I.N.	19. Dentist license no.	20. Dentist phone no.	27. If prosthesis, is this initial placement?		If no, reason for replacement	28. Date of prior placement

21. First visit date current series	22. Place of treatment Office Hosp ECF Other	23. Radiographs or models enclosed	No	Yes	How many?	29. Is treatment for orthodontics?			If services already commenced enter:	Date appliance placed:	Mos. treatment remaining:

Identify missing teeth with 'x'



30. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service Performed Mo.	Day	Year	Procedure Number		Fee		For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

► _____
Signed (Treating Dentist) License Number NPI Date

Total fee charged

Customer service phone number – **1 (800) 4 DENTAL**

Max. allowable	
Deductible	
Carrier %	
Carrier pays	
Patient Pays	