Reset Form

Horizon Blue Cross Blue Shield of New Jersey

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 M F	4. Patient birth date MM DD YYYY	5. Full time student ☐ yes ☐ no If yes: School / City
	☐ self ☐ child ☐ spouse ☐ other _____			

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

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

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 MM DD YYYY	15. Relationship to patient ☐ 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**

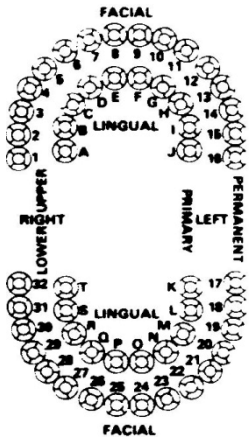
BILLING DENTIST

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

Max. allowable	
Deductible	
Carrier %	
Carrier pays	
Patient Pays	

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