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 ☐ self ☐ child ☐ spouse ☐ other ___________	3. Sex M F	4. Patient birth date MM DD YYYY	5. Full time student ☐ 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 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.

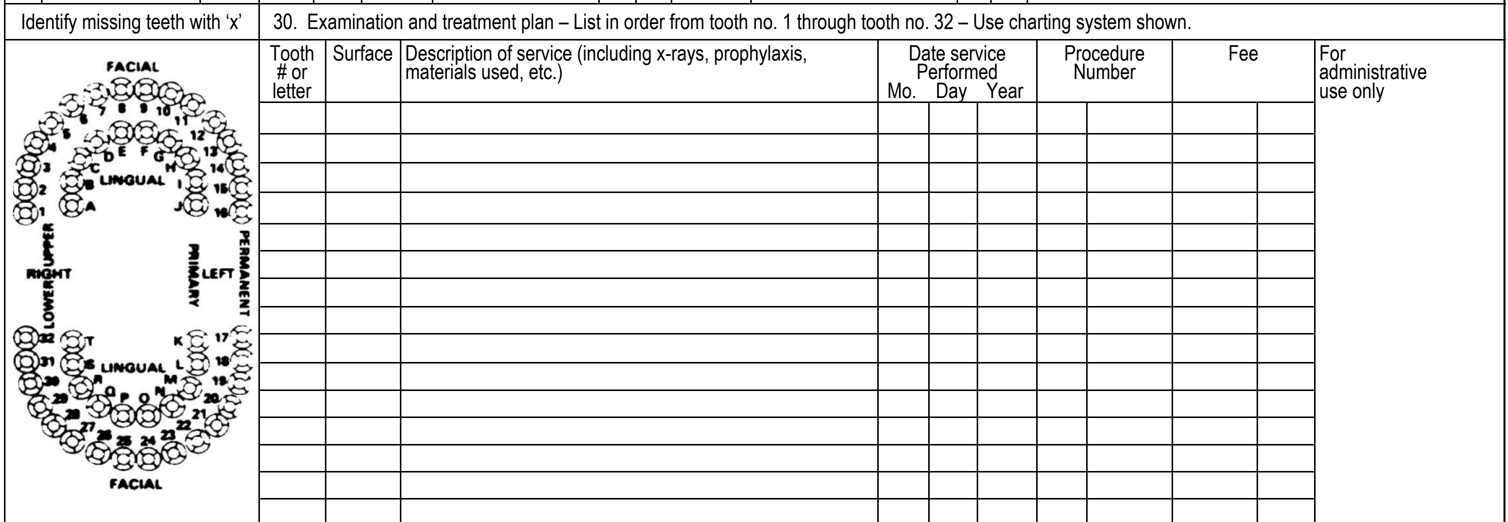
► ______________________________________
Signed (insured person) **Date**

BILLING DENTIST

				No	Yes	
16. Name of Billing Dentist or Dental Entity			24. Is treatment result of occupational illness or injury?			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**