



## HOW TO COMPLETE A CLAIM

The Dental Service Report is the most vital link between you and Horizon Blue Cross Blue Shield of New Jersey. We have tried to design the Service Report so that it is easy to complete. If you need more help, call us at 1-800-4DENTAL between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

### COMPLETED BY SUBSCRIBER (Please print clearly):

1. **PATIENT'S NAME (Last, First and Initial)** - Fill in name of the person treated.
2. **PATIENT'S DATE OF BIRTH** - Enter month / day / year. If left blank, payment will be delayed.
3. **SEX** - Check off the sex of the patient.
4. **IDENTIFICATION NUMBER** - Enter subscriber's identification number.
5. **APPLICANT - SUBSCRIBER NAME (Last, First and Initial)** - Include the name and complete address, including zip code, of the subscriber.
6. **RELATIONSHIP OF PATIENT TO APPLICANT - SUBSCRIBER** - Check one of the following:
  - (1) SELF if the patient is the subscriber;
  - (2) SPOUSE if the patient is the husband or wife of the subscriber;
  - (3) DEPENDENT if patient is a dependent (daughter/son) of the subscriber.
- \* 7. **FULL TIME STUDENT** - Check off box if patient is a full time student.
- \* 8. **DISABLED DEPENDENT** - Check off box if patient is a disabled dependent.  
*\*Please attach verification if patient is over contract age limits:*  
**Full Time Student** - Copy of the most recent bill from accredited college or university.  
**Disabled Dependent** - verification patient is disabled from physician.
9. **WAS INJURY OR CONDITION RELATED TO** - If not applicable, leave blank.
10. **DATE OF INJURY (ACCIDENT)** - If services are performed as the result of an accidental injury, the date of injury is needed to determine patient's eligibility.
11. **IS THIS PATIENT COVERED BY ANOTHER DENTAL CARRIER** - If payment has been made by another carrier, please supply the Explanation of Benefits (EOB) from the carrier.
12. **PATIENT'S AUTHORIZATION** - Must be completed signed by the subscriber if patient is a minor.
13. **ASSIGNMENT OF BENEFITS** - Must be signed if you would like payment sent directly to the attending dentist.

### COMPLETED BY DENTIST (Please print clearly):

14. **IF CROWN, INLAY/ONLAY OR PROSTHESIS - IS THIS THE INITIAL PLACEMENT** - The Plan does not cover replacements made less than five (5) years after initial placement.  
**DATE OF IMPRESSION** - The date crown or bridgework started.
15. **IS TREATMENT FOR ORTHODONTIC CARE** - Complete dates where applicable.
16. **COMPLETE EXAMINATION AND TREATMENT RECORD IN FULL** - If necessary to use more lines than provided, place check in the space provided to alert claims examiners of more than one form.
17. **FOR HOSPITAL CASES ONLY** - Provide the name of the institution, city in which it is located and the dates of admission and discharge.
18. **DENTIST'S NAME, ADDRESS AND ZIP CODE** - Enter dentist's correct name, current address and Taxpayer Identifying Number or Social Security Number. If dentist has multiple offices, indicate the multiple office code.
19. **DENTIST'S REQUEST FOR PREDETERMINATION OR PAYMENT** - Check the appropriate block. Predetermination and payment may be requested on the same form. If you request both predetermination and payment on the same form, the Predetermination Approval Form and either a check or an explanation of benefits will be mailed under separate cover.
20. **DENTIST'S SIGNATURE/TELEPHONE NUMBER.**