

Missing Teeth Information

34. (Place an "X" on each missing tooth)	Permanent																Primary									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

35. Remarks

Authorizations

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. Applicable to Accident and Health.

X

Patient/guardian signature

Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X

Subscriber signature

Date

Ancillary Claim/Treatment Information

38. Place of treatment (check applicable box)				39. Number of enclosures (00 to 99)			
<input type="checkbox"/> provider's office	<input type="checkbox"/> ECF	<input type="checkbox"/> hospital	<input type="checkbox"/> other	<input type="checkbox"/> photographs(s)	<input type="checkbox"/> oral image(s)	<input type="checkbox"/> model(s)	
40. Is treatment for orthodontics?				41. Date appliance placed (mm/dd/yyyy)		42. Months of treatment remaining	
<input type="checkbox"/> no (skip 41-42) <input type="checkbox"/> yes (complete 41-42)							
43. Replacement of prostheses?				44. Date appliance placed (mm/dd/yyyy)		45. Treatment resulting from (check applicable box)	
<input type="checkbox"/> no <input type="checkbox"/> yes (complete 44)						<input type="checkbox"/> occupational illness/injury <input type="checkbox"/> auto accident <input type="checkbox"/> other accident	
46. Date of accident (mm/dd/yyyy)				47. Auto accident state			

Billing Dentist or Dental Entity

(Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, address, city, state, ZIP code

49. Provider ID	50. License number	51. SSN or TIN	52. Phone number
_____	_____	_____	_____

Treating Dentist and Treatment Location Information

53. 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.

X

Signed (treating dentist)

Date

54. Provider ID	55. License number	56. Address, city, state, ZIP code
_____	_____	_____
57. Phone number	58. Treating provider specialty	
_____	_____	

USE THIS FORM FOR BOTH EMPLOYEE AND DEPENDENT CLAIMS

Instructions to the Employee

1. Have patient's dentist complete questions 1 through 58.
2. If you want benefits paid directly to the dentist, sign the authorization to pay under the Authorizations section.
3. If charges exceed either \$200.00 or \$300.00 (or as specified in your Benefit Plan Booklet), a treatment plan may be submitted prior to continuation of treatment.

Instructions to the Dentist

Statement of actual charges.

1. Show the date the work was completed for each service and the corresponding fee.
2. Return this form to Nippon Life Insurance Company of America (Nippon Life Benefits) (address printed on member's ID card).

Request for predetermination.

1. Describe procedures necessary to fully complete the treatment plan. State your fees, enclose x-rays (these will be returned to you) and return the form to Nippon Life Benefits (address printed on member's ID card).
2. Nippon Life Benefits will provide written response indicating the benefits that may be payable for the proposed treatment.

Notice!!

The pre-determined benefits apply only to expenses incurred while employee's coverage is in force.

Pre-determination of dental services is intended to avoid any misunderstandings between the dentist, employee, and Nippon Life Benefits. Patient waives advanced knowledge when not obtaining a pre-determination and is liable if the plan doesn't pay or partially pays for treatment.

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

District of Columbia: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.