Nippon Life Benefits®

Attending Dentist's Statement – NJ

Please mail completed form to:
Nippon Life Insurance Company of America
Attn: Claim Center
P.O. Box 25951
Shawnee Mission, KS 66225-5951

For questions, please refer to the Benefit Phone # on your ID card.

Attending Dentist's Statement

1. Type of transaction (check all applicable boxes)
☐ statement of actual services -OR- ☐ Request for predetermination/preauthorization* ☐ EPSOT/title XIX

2. Predetermination/preauthorization #:

Primary Payer Information

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

Other Coverage

4. Other dental coverage? ☐ no (skip 5-11) ☐ yes (complete 5-11)
Other medical coverage? ☐ no (skip 5-11) ☐ yes (complete 5-11)

5. Subscriber name (last, first, middle initial, suffix)

6. Date of birth (mm/dd/yyyy)

7. Gender ☐ M ☐ F

8. Subscriber identifier (SSN or ID#)

9. Plan/group number

10. Relationship to primary subscriber (check applicable box) ☐ self ☐ spouse ☐ dependent ☐ other

11. Other carrier name, address, city, state, ZIP code

Primary Subscriber Information

12. Name (last, first, middle initial, suffix), address, city, state, ZIP code

13. Date of birth (mm/dd/yyyy)

14. Gender ☐ M ☐ F

15. Subscriber identifier (SSN or ID #)

16. Plan/group number

17. Employer name

Patient Information

18. Relationship to primary subscriber ☐ self ☐ spouse ☐ dependent child ☐ other

19. Student status ☐ full time ☐ part time

20. Name (last, first, middle initial, suffix), address, city, state, ZIP code

21. Date of birth (mm/dd/yyyy)

22. Gender ☐ M ☐ F

23. Patient ID/account # (assigned by dentist)

Record of Services Provided

	24. Procedure date (mm/dd/yyyy)	25. Area of oral cavity	26. Tooth system	27. Tooth number(s) or letter(s)	28. Tooth surface	29. Procedure code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
							32. Other fee(s)	
							33. Total fee	

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. **Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.**

X

Patient/guardian signature

Date

Authorizations (continued)

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)
☐ provider's office ☐ ECF ☐ hospital ☐ other

39. Number of enclosures (00 to 99)
☐ photograph(s) ☐ oral image(s) ☐ model(s)

40. Is treatment for orthodontics?
☐ no (skip 41-42) ☐ yes (complete 41-42)

41. Date appliance placed (mm/dd/yyyy)

42. Months of treatment remaining

43. Replacement of prosthesis?
☐ no ☐ yes (complete 44)

44. Date appliance placed (mm/dd/yyyy)

45. Treatment resulting from (check applicable box)
☐ occupational illness/injury ☐ auto accident ☐ 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 $300.00 (as specified in your Benefit Plan Booklet), a predetermination may be submitted prior to continuation of treatment. Predetermination/preauthorization is not mandatory.

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.