Reset Form

Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

Authorization # _____

HORIZON DENTAL CHOICE

Orthodontic Referral Authorization Form

Please print **1-800-4DENTAL**

PATIENT'S NAME (last, first and initial)	PATIENT'S DATE OF BIRTH	SEX ☐M ☐F	REFERRING DENTIST / OFFICE ID NUMBER
APPLICANT'S/SUBSCRIBER'S NAME (last, first and initial)	RELATIONSHIP OF PATIENT TO APPLICANT/SUBSCRIBER ☐SELF ☐SPOUSE ☐DEPENDENT		SERVICING DENTIST / TAX ID NUMBER
ADDRESS (Street, City, State, Zip Code)			ADDRESS / CURRENT DATE
MEMBER ID NUMBER	DAYTIME PHONE NUMBER	GROUP NUMBER	TELEPHONE NUMBER

PATIENT AUTHORIZATION: I authorize release of all necessary treatment records to Horizon Healthcare Dental and direct Horizon Healthcare Dental to pay benefits directly to the provider of services.

PATIENT/PARENT SIGNATURE **DATE**

AUTHORIZATION IS VALID FOR 90 DAYS FROM APPROVAL DATE

TO BE COMPLETED BY ORTHODONTIST

INSTRUCTIONS: Please provide the information requested below and return this form with a narrative to the address shown below.

PATIENT HISTORY

Is Patient currently receiving orthodontic treatment? ☐ Yes ☐ No

Name/Address of Orthodontist: _____ Date treatment started: _____

_____

Has patient previously received orthodontic treatment? ☐ Yes ☐ No

Name/Address of Orthodontist: _____

Dates treatment rendered: From _____ To _____

Description of prior treatment (if known): _____

DIAGNOSIS

Type of Dentition: ☐ Primary ☐ Mixed ☐ Adult

Type of Malocclusion: ☐ Class ☐ I ☐ II ☐ III

Narrative Description of Diagnosis:

TREATMENT PLAN

Treatment Required: $ _____Total Treatment Fee _____ Months of Active Treatment _____ Months of Retention _____ None

Narrative Description of Treatment _____

Orthodontist's Signature _____ Date _____

FOR HORIZON DENTAL CHOICE USE ONLY

☐ Eligible for Specialty Business

☐ Partially eligible for Specialty Benefits (see comments below)

☐ Not eligible for Specialty Benefits (see comments below)

☐ Other (see comments below)

Patient Copayment Percent = _____ % of Orthodontist Fee.

(Copayment in effect at the time charges are incurred will apply.)

Comments: _____

Evaluated by: _____ Date _____

Mail To: Horizon Healthcare Dental
PO Box 1311
Minneapolis MN 55440-1311

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