Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

HORIZON DENTAL CHOICE

Periodontal Specialty 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

INITIAL CHARTING – SUPPORTING X-RAYS AND PERIODONTAL PROBE CHARTING MUST BE INCLUDED

1 2 3 4 5 6 7 8 UPPER 9 10 11 12 13 14 15 16

RIGHT-- LINGUAL --LEFT

32 31 30 29 28 27 26 25 LOWER 24 23 22 21 20 19 18 17

X-Rays: ______________________ **Perio Exam:** ______________________ **Scaling and Root Planing:** ______________________

Date Taken **Date** **Date Completed**

CHARTING AT RE-EVALUATION

Re-evaluation ______________________

Date

1 2 3 4 5 6 7 8 UPPER 9 10 11 12 13 14 15 16

RIGHT-- LINGUAL --LEFT

32 31 30 29 28 27 26 25 LOWER 24 23 22 21 20 19 18 17

THE CASE MUST BE TYPE III OR IV FOR SPECIALTY REFERRAL

Evaluated by: ______________________ **Date:** ______________________

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

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