Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

RESET

Authorization # _____

HORIZON DENTAL CHOICE

Specialty Service 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

Is patient covered by another dental carrier? ☐ Yes ☐ No

If yes,

Carrier's Name: _____ Policy No: _____

Address/State: _____

FATHER'S DATE OF BIRTH	MOTHER'S DATE OF BIRTH

DIAGNOSTIC MATERIALS ATTACHED

☐ x-rays ☐ perio charting

☐ other: _____

TOOTH NO.

DIRECT REFERRAL SERVICES:

Periodontics	Consultation and treatment for advanced Periodontics cases.
Endodontics:	Molar root Canal Treatment Retreatment of Anterior, Bi-Cuspid and Molar Root Canals Apicoectomy
Oral Surgery:	Bony impactions Partial Bony Impactions Residual Root Surgical Removal Apicoectomy
Orthodontics:	Consultation only
Pediatric Care:	Dental treatment for documented unmanageable children age 5 and under

FOR HORIZON HEALTHCARE DENTAL 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)

If a Copayment Percent is applicable for the approved Specialty Dental Services, it is indicated below.

☐ A ____ % Copayment applies to: _____ ☐ None (A Copayment is not applicable)

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

Comments: _____

Evaluated by: _____ Date _____

Mail To: Horizon Healthcare Dental
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Minneapolis MN 55440-1311