Nippon Life Benefits®

Nippon Life Insurance Company of America
Attn: Claim Center
P.O. Box 4387
Clinton, IA 52733

Attending Dentist's Statement

Please mail completed form to the address above. 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 ☐ EPSDT/title XIX or ☐ request for predetermination/preauthorization

2. Predetermination/preauthorization number

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 child ☐ 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/Group # (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.

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)

☐ provider's office ☐ ECF ☐ hospital ☐ other

39. Number of enclosures (00 to 99)

☐ photographs(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 prostheses?

☐ 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 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.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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.

Oklahoma Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Virginia: Any person who, with the 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 may have violated state law.

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.