



BENEFIT FROM OUR DEDICATED SERVICE

Nippon Life Insurance Company of America

PO Box 39710

Colorado Springs, CO 80949-3910

Attending Dentist's Statement

Please mail completed form to the address above. For questions, please refer to the toll-free number printed on your ID card.

Attending Dentist's Statement

1. Type of transaction (check all applicable boxes)

statement of actual services EPSOT/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

Other medical coverage

no (skip 5-11) yes (complete 5-11) 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

8. Subscriber identifier (SSN or ID#)

9. Plan/group number

M F

10. Relationship to primary subscriber (check applicable box)

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

self spouse dependent child other

Primary Subscriber Information

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

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

14. Gender

15. Subscriber identifier (SSN or ID#)

16. Plan/group number

17. Employer name

M F

Patient Information

18. Relationship to primary subscriber

19. Student status

self spouse dependent child other

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

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

M F

Record of Services Provided

Table with 9 columns: 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, 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.

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) 39. Number of enclosures (00 to 99)

provider's office ECF hospital other photographs(s) oral image(s) model(s)

40. Is treatment for orthodontics? 41. Date appliance placed (mm/dd/yyyy) 42. Months of treatment remaining

no (skip 41-42) yes (complete 41-42) _____

43. Replacement of prostheses? 44. Date appliance placed (mm/dd/yyyy) 45. Treatment resulting from (check applicable box)

no yes (complete 44) _____ 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 (NLI America) (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 NLI America (address printed on member's ID card).
2. NLI America 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 NLI America. 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, 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, may be guilty of insurance fraud.