

Signature on File Dentist Authorization Form Electronic Submission

Print, complete and mail this form to Professional Relations Department, Dental Programs,
3 Penn Plaza East PP-04Q, Newark, NJ 07105 or Fax to (973) 274-4154.

Email Address: _____

Dentist Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax: _____

Dentist License #: _____ NPI #: _____

Organization Name: _____
(as filed with Tax Identification Number)

Tax Identification Number: _____

Practice Management Software: _____ *Provider Site ID: _____

(*If submitting for more than one location -- Obtain from your Practice Management Software)

"I hereby certify that I will obtain each patient's duly executed authorization to submit claims or predeterminations to you before I transmit a manual or electronic claim to you for that patient. I further agree to maintain signed authorization in my patient record for at least four years from the date of the last claim I submit to you for that patient and to produce it to you for copying upon your request. I hereby authorize you to accept this form as my certification to you of the accuracy of all information contained in each claim or predetermination which I submit to you manually or electronically (for electronic claims, this includes those claims I submit directly to you or which re submitted with my identification code with a clearinghouse). For each such submission: (a) the fee reported to you shall be the usual fee I charge for those services; (b) the date of each service for treatment rendered shall be the date when the service was completed (except in the case of predeterminations); (c) the fee I submit to you as having been paid by any primary carrier will be the actual fee paid by the primary carrier, if one exists; and (d) all services shall have been necessary in my professional judgement.

I hereby agree to notify you in writing within 60 days of my receipt of a claim or predetermination from you as to any discrepancy between the information I submitted to you electronically and the information contained in your payment notice or predetermination. I agree not to assert that I transmitted different information to you unless I have given you timely notice of the discrepancy. This certification and authorization will remain in effect until you have received my written notice addressed to your Dental Director, 3 Penn Plaza East, PP04Q, Newark, NJ 07105, that I have terminated authorization; it will remain in effect for all claims received by you through the date when you receive that written notice of termination."

Signature _____ Date: _____

Note: Each dentist in the office rendering treatment and submitting claims must sign a separate authorization form for use of signature on file.