Rayant Insurance Company of New York
Rayant Insurance Company of Pennsylvania
Horizon Companies

Send Correspondence to:
Rayant - Dental Programs
3 Penn Plaza East PP-03Q
Newark, NJ 07105-2200
1-888-667-4547
www.rayant.com

Signature on File Dentist Authorization Form
Electronic Submission

Print, complete and mail this form to Professional Relations Department, Rayant Dental Programs, 3 Penn Plaza East PP-03Q, 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 resubmitted 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 Director of Claims, Rayant Dental Services, 3 Penn Plaza East, PP-03Q, 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.

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