rayant℠

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

# DENTAL SERVICE REPORT

Rayant-Dental Programs
Send Correspondence to:
P.O. Box 1938
Newark, NJ 07101-1938
**1-888-667-4547**
www.rayant.com

**-PLEASE PRINT-**

## PATIENT SECTION

1. **PATIENT'S NAME** *(Last, First, and Initial)*

2. **PATIENT'S DATE OF BIRTH** Mo. Day Yr.

3. **SEX** (1) M ☐ (2) F ☐

4. **IDENTIFICATION NUMBER**

5. **APPLICANT-SUBSCRIBER'S NAME** *(Last, First, and Initial)*
**ADDRESS** *(Street, City, State, Zip Code)*

TEL NO. ( )

**CHECK IF THIS A NEW ADDRESS** ☐

6. **RELATIONSHIP OF PATIENT TO APPLICANT-SUBSCRIBER**
(1) Self ☐ (2) Adult Dependent ☐ (3) Dependent ☐

7. **FULL TIME STUDENT** (1) Yes ☐ (2) No ☐

8. **DISABLED DEP.** (1) Yes ☐ (2) No ☐

9. **WAS INJURY OR CONDITION RELATED TO:**
(1) Patient Employment ☐ (3) Auto Accident ☐
(2) Neither Employment nor Auto ☐ (4) Both Employment and Auto ☐

10. **DATE OF INJURY (ACCIDENT)** Mo. Day Yr.

11. **IS PATIENT COVERED BY ANOTHER DENTAL CARRIER?** (1) Yes ☐ (2) No ☐
If Yes; Carrier Name _____ Policy Number _____
Father's Date of Birth _____
Mother's Date of Birth _____
Address/State _____

12. **PATIENT'S AUTHORIZATION** - I hereby accept the above treatment plan and authorize release of any information pertaining to the case. I am aware that the dentist is ( ) is not ( ) a participating dentist.

Patient's Signature (or Parent if Patient is minor) Date

13. **IF CONTRACTUALLY PERMITTED BY MY MASTER CONTRACT I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME**

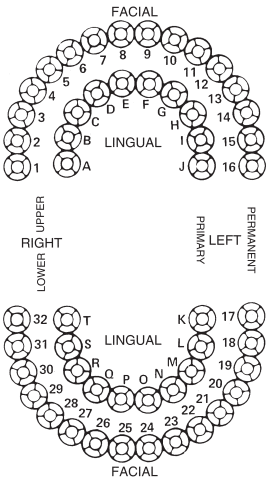
**SIGNED (INSURED PERSON)** **DATE**

## DENTIST SECTION

14. If crown, inlay/onlay or prosthesis - is this the initial placement?
(1) Yes
(2) No
IF NO { Date of Prior Placement *Mo./Day/Yr.* _____
Reason for Replacement _____
DATE OF IMPRESSION _____ DATE OF INSERTION _____

15. IS TREATMENT FOR ORTHODONTIC CARE? (1) Yes ☐ (2) No ☐
Date 1st Appliance Inserted _____
Date Last Appliance Removed _____

IDENTIFY MISSING TEETH WITH "X"




16. **COMPLETE EXAMINATION AND TREATMENT RECORD IN FULL**
List in sequential order from tooth number 1-32 or tooth A-T ... If requesting predetermination - omit date of service performed.
If more line items are needed please use an additional claim form and attach - completing items 1 and 5 above and check here. ☐

| TOOTH NO. OR LETTER | SURFACES | DATES OF SERVICES MO. DAY YR. | DESCRIPTION OF SERVICES (including X-rays, Prophylaxis, Materials used, Etc.) | QTY. | PROCEDURE CODE | AMOUNT CHARGED |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | TOTAL CHARGES | |

17. FOR HOSPITAL CASES ONLY
NAME OF HOSPITAL & CITY & STATE
DATE ADMITTED MO _____ DAY _____ YR. _____ DATE DISCHARGED MO _____ DAY _____ YR. _____

18. DENTIST'S NAME, ADDRESS AND ZIP CODE

TAXPAYER'S IDENTIFICATION NO.

19. **DENTIST'S REQUEST FOR PREDETERMINATION OR PAYMENT**
(Please check appropriate box)

☐ (1) Request for Predetermination - I certify that I am legally qualified to perform the reported services. The fees shown are those usually charged to my private, non-insured patients.

☐ (2) Request for payment - I hereby certify that the procedures as indicated by date have been completed by me personally or under my direct supervision. The fees shown are those usually charged to my private, non-insured patients. I have read the fraud warning below.

20. Dentist's Signature _____
TELEPHONE NUMBER (Including Area Code) _____

**TO AVOID DELAY OR PROCESSING:**
**Please proofread claim. Make sure all pertinent information has been completed.**

**FRAUD WARNING**
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.

rayant℠

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

# HOW TO COMPLETE A CLAIM

The Dental Service Report is the most vital link between you and Rayant. We have tried to design the Service Report so that it is easy to complete. If you need more help, call us at 1-888-667-4547 between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday.

## COMPLETED BY SUBSCRIBER *(Please print clearly):*

1. **PATIENT'S NAME (Last, First and Initial)** - Fill in name of the person treated.
2. **PATIENT'S DATE OF BIRTH** - Enter month / day / year. If left blank, payment will be delayed.
3. **SEX** - Check off the sex of the patient.
4. **IDENTIFICATION NUMBER** - Enter subscriber's identification number.
5. **APPLICANT - SUBSCRIBER NAME (Last, First and Initial)** - Include the name and complete address, including zip code, of the subscriber.
6. **RELATIONSHIP OF PATIENT TO APPLICANT - SUBSCRIBER** - Check one of the following:
   (1) SELF if the patient is the subscriber;
   (2) ADULT DEPENDENT if a patient is a dependent spouse or domestic partner of the subscriber.
   (3) DEPENDENT if a patient is a dependent son or daughter of the subscriber.

* 7. **FULL TIME STUDENT** - Check off box if patient is a full time student.

* 8. **DISABLED DEPENDENT** - Check off box if patient is a disabled dependent.
**Please attach verification if patient is over contract age limits:*
***Full Time Student*** *- Copy of the most recent bill from accredited college or university.*
***Disabled Dependent*** *- verification patient is disabled from physician.*

9. **WAS INJURY OR CONDITION RELATED TO** - If not applicable, leave blank.
10. **DATE OF INJURY (ACCIDENT)** - If services are performed as the result of an accidental injury, the date of injury is needed to determine patient's eligibility.
11. **IS THIS PATIENT COVERED BY ANOTHER DENTAL CARRIER** - If payment has been made by another carrier, please supply the Explanation of Benefits (EOB) from the carrier.
12. **PATIENT'S AUTHORIZATION** - Must be completed signed by the subscriber if patient is a minor.
13. **ASSIGNMENT OF BENEFITS** - Must be signed if you would like payment sent directly to the attending dentist.

## COMPLETED BY DENTIST *(Please print clearly):*

14. **IF CROWN, INLAY/ONLAY OR PROSTHESIS - IS THIS THE INITIAL PLACEMENT** - The Plan does not cover replacements made less than five (5) years after initial placement.
    **DATE OF IMPRESSION** - The date crown or bridgework started.
15. **IS TREATMENT FOR ORTHODONTIC CARE** - Complete dates where applicable.
16. **COMPLETE EXAMINATION AND TREATMENT RECORD IN FULL** - If necessary to use more lines than provided, place check in the space provided to alert claims examiners of more than one form.
17. **FOR HOSPITAL CASES ONLY** - Provide the name of the institution, city in which it is located and the dates of admission and discharge.
18. **DENTIST'S NAME, ADDRESS AND ZIP CODE** - Enter dentist's correct name, current address and Taxpayer Identifying Number or Social Security Number. If dentist has multiple offices, indicate the multiple office code.
19. **DENTIST'S REQUEST FOR PREDETERMINATION OR PAYMENT** - Check the appropriate block. Predetermination and payment may be requested on the same form. If you request both predetermination and payment on the same form, the Predetermination Approval Form and either a check or an explanation of benefits will be mailed under separate cover.
20. **DENTIST'S SIGNATURE/TELEPHONE NUMBER.**