



Horizon Blue Cross Blue Shield of New Jersey

Dental Programs

P.O. Box 1938
Newark, NJ 07101-1938
www.HorizonBlue.com

To All Employees:

As you are aware, your Dental program will now be administered by Horizon BCBSNJ Dental Programs.

In order to receive all eligible benefits and credits, we need your help. If you and/or any covered family members has met all or part of the deductible under your prior Dental program, we would like to know so that we may apply it to your new plan.

To be credited with this “carry-over” deductible, kindly follow these few basic steps:

1. Fully complete the attached Dental Deductible Carry-over Credit Report. If additional forms are required for your dependents, you may obtain another form from your Employee Benefits Office.
2. Include the most current Explanation of Benefits from your previous carrier which shows the amount of the deductible taken for each dependent.

With this information on record, duplicate deductibles will not be a problem with future claims.

It is important to return all completed reports, prior to your first claim submission, to your Employee Benefits Department within two weeks from receipt of this letter.

Thank you for your cooperation in this matter.

THIS FORM CAN BE DOWNLOADED FROM OUR WEB SITE AT www.HorizonBlue.com

Horizon BCBSNJ Dental Programs Dental Deductible Carry-Over Credit Report

Group Name: _____

Group Number: _____

ID # _____

Patient Name: _____
(Last) (First)

Subscriber Name: _____
(Last) (First)

Subscriber's Address: _____
(Street) (County)

(City) (State) (Zip)

Patient's Relationship: _____ Sex _____

Patient's Date of Birth: _____

Amount of Deductible Met: _____

Please attach explanation of benefits showing deductible amount.