CLAIM RESOLUTION PROGRAM
New Jersey Dental Association
One Dental Plaza
P.O. Box 6020
North Brunswick, NJ 08902

Desire Assistance _____ No Action Required _____

DENTIST INFORMATION

Last Name: _____ First: _____ M.I.:_____

ADA Member #: _____ Specialty: _____ Phone: _____

Your Component Dental Society: _____

INSURED INFORMATION - SUBSCRIBER

Last Name: _____ First: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Original Claim: _____Social Security #: _____ Phone: _____

PATIENT – (If Different from Subscriber)

Last Name: _____ First: _____ M.I.: _____
Relationship to Subscriber: Self (1) _____ Spouse (2) _____ Child (3) _____ Other (4) _____

I hereby authorize release of any information relating to this claim, including but not limited to charts, x-rays, and other records of my treatment, to any appropriate agency, the American Dental Association, and any of its constituent or component dental societies.

_____ _____
Patient's Signature (Parent, If Minor) Date

EMPLOYER INFORMATION

Name: _____

(Please complete the following information if known)
Address: _____

City: _____ State: _____ Zip Code: _____

Plan Type (Medical, Dental, PIP, etc.): _____

THIRD PARTY INFORMATION

Name of Insurance Company

Address: _____

City: _____ State: _____ Zip Code: _____

Nature of Complaint – Please check all categories that apply

____ AOB=Assignment of Benefits
____ BND=Bundling
____ COB=Coordination of Benefits
____ DCR=Dentist Consultant Review
____ DEC=Denial of Claim
____ DLR=Delay/Lack of Response
____ EOB=Explanation of Benefits
____ LMC=Lost/Misplaced Claim
____ LMR=Lost/Misplaced Radiographs
____ REF=Refund Request
____ TOR=Treatment of Relative
____ UCC=Unauthorized ADA Code Change
____ UCR=UCR Fee Dispute
____ UNR=Unqualified Claim Review

____ OTH=Other_____

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