CSEA EMPLOYEE BENEFIT FUND **DENTAL CLAIM FORM**

◊ Statement of Actual Completed Services

◊ Pretreatment Estimate/Predetermination

SUBSCRIBER NAME (Last, First, Middle Initial)

HOME ADDRESS

SEND CLAIM FORM TO:

CSEA EMPLOYEE BENEFIT FUND
PO BOX 489
LATHAM, NY 12110-0489

PHONE NUMBER: (800) 323-2732

Date of Birth (mm/dd/ccyy) **Gender** ☐ Male ☐ Female

SUBSCRIBER ID NUMBER

PATIENT NAME (Last, First, Middle Initial)

Other Coverage (Provide Name of Company)

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

Policy Holder

Date of Birth (mm/dd/ccyy) **Gender** ☐ Male ☐ Female

RECORD OF SERVICES PROVIDED

DATE OF SERVICE	PROCEDURE CODE	TOOTH #/ LETTER / QUAD	SURFACE	DESCRIPTION OF SERVICE	FEE

REMARKS: **TOTAL**

MISSING TEETH (Mark each missing tooth with an X.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 A B C D E F G H I J
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 T S R Q P O N M L K

SUBSCRIBER AUTHORIZATIONS:

I hereby certify that the dated procedures have been completed.

_____

Please issue payment directly to the dentist or dental entity below.

_____

ADDITIONAL INFORMATION

Radiographs enclosed? _____
Is treatment for orthodontics? Yes or No
Date of insertion? _____
Replacement of prosthesis? Yes or No
Date of prior placement? _____

BILLING DENTIST OR DENTAL ENTITY (Name and address)

_____
_____
_____

NPI	License Number	TIN or SSN

Phone Number

TREATING DENTIST

I certify that the dated procedures on the claim form have been completed.

_____
Treating Dentist Signature

_____
Date

NPI	License

CSEA AFSCME Local 1000, AFL-CIO EMPLOYEE BENEFIT FUND