CSEA EMPLOYEE BENEFIT FUND **DENTAL CLAIM FORM**

◊ Statement of Actual Completed Services

◊ Pretreatment Estimate/Predetermination

SUBSCRIBER NAME (Last, First, Middle Initial) 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 (please circle)** M F

SUBSCRIBER ID NUMBER

PATIENT NAME (Last, First, Middle Initial)

Other Coverage (Provide Name of Company)

Relationship to Subscriber (please circle)
Self Spouse Dependent Child Other

Policy Holder

Date of Birth (mm/dd/ccyy) **Gender (please circle)** M F

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