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
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

A	B	C	D	E	F	G	H	I	J
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