Reason for submission (Please ✓ one):

☐ Statement of Actual Completed Services

☐ Pretreatment Estimate/Predetermination

DENTAL CLAIM FORM

www.cseaebf.com 800-323-2732

Claim Address: PO Box 489 Latham NY 12110-0489

CSEA NEW YORK Employee Benefit Fund

MEMBER INFORMATION

Member's Name_____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy)_____

☐ Male ☐ Female (Check one) ☐ Other

EBF ID Number_____

Street Address_____

City_____ State_____ Zip_____

PATIENT INFORMATION

Patient's Name_____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy)_____

☐ Male ☐ Female (Check one) ☐ Other

Relationship to Member (Check one)

☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

OTHER COVERAGE INFORMATION

Is other Dental coverage available? (Check one) ☐ Yes ☐ No

Name of Company_____

Other Dental Company Claim Address_____

_____

_____

_____

City_____ State_____ Zip_____

Policyholder's Name_____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy)_____

☐ Male ☐ Female (Check one) ☐ Other

ID Number_____

Plan/Group Number_____

Patient Relationship to Member (Check one)

☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

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
32	31	30	29	28	27	26	25

9	10	11	12	13	14	15	16
24	23	22	21	20	19	18	17

A	B	C	D	E
T	S	R	Q	P

F	G	H	I	J
O	N	M	L	K

MEMBER AUTHORIZATION

I hereby certify that the dated procedures have been completed.

X _____

Please issue payment directly to the dental entity below.
(Leave this field blank for payment to be sent to the member.)

X _____

ADDITIONAL INFORMATION

Radiographs enclosed? (Yes/No)_____

Is treatment for orthodontics? (Yes/No)_____

Date of insertion? (dd/mm/yyyy)_____

Replacement of prosthesis (Yes/No)_____

Date of prior placement? (dd/mm/yyyy)_____

BILLING DENTIST OR DENTAL ENTITY (NAME AND ADDRESS)

NPI	License #	TIN or SSN

Phone Number

TREATING DENTIST AUTHORIZATION

Treating Dentist Sign Below

X _____

Date (mm/dd/yyyy)_____

NPI	License #