**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 # |
|---|---|
| | |