

Reason for submission (Please ✓ one):

Statement of Actual Completed Services

Pretreatment Estimate/Predetermination

DENTAL CLAIM FORM

www.cseabf.com 800-323-2732

Claim Address: PO Box 489 Latham NY 12110-0489



SUBSCRIBER INFORMATION	PATIENT INFORMATION
Subscriber's Name _____ <small>First Name, Middle, Last Name</small>	Patient's Name _____ <small>First Name, Middle, Last Name</small>
Date of Birth (mm/dd/yyyy) _____	Date of Birth (mm/dd/yyyy) _____
<input type="checkbox"/> Male <input type="checkbox"/> Female (Check one)	<input type="checkbox"/> Male <input type="checkbox"/> Female (Check one)
Subscriber's EBF ID Number _____	Relationship to Subscriber (Check one)
Street Address _____	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other
City _____ State _____ Zip _____	

OTHER COVERAGE INFORMATION	
Is other Dental coverage available? (Check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	Subscriber's Name _____ <small>First Name, Middle, Last Name</small>
Name of Company _____	Date of Birth (mm/dd/yyyy) _____
Other Dental Company Claim Address _____	<input type="checkbox"/> Male <input type="checkbox"/> Female (Check one)
_____	Subscriber's ID Number _____
_____	Plan/Group Number _____
City _____ State _____ Zip _____	Patient Relationship to Subscriber (Check one)
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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	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 AUTHORIZATION	ADDITIONAL INFORMATION
I hereby certify that the dated procedures have been completed. X _____	Radiographs enclosed? (Yes/No) _____
Please issue payment directly to the dental entity below. X _____	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)	TREATING DENTIST
	Treating Dentist Sign Below
	X _____
NPI _____	Date (mm/dd/yyyy) _____
License # _____	NPI _____
TIN or SSN _____	License # _____
Phone Number _____	