DENTAL CLAIM FORM

◊ Statement of Actual Completed Services					SUBSCRIBER NAME (Last, First, Middle Initial) ADDRESS			
♦ Pretreatment Estimate/Predetermination								
SEND CLAIM FORM TO:					Date of Birth (mm/dd/ccyy) Gender (please circle) M F			
CSEA EMPLOYEE BENEFIT FUND PO BOX 489					SUBSCRIBER ID NUMBER			
LATHAM, NY 12110-0489					PATIENT NAME (Last, First, Middle Initial)			
	NUMBER:	(800) 323-						
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		TOOTH #/ LETTER / QUAD	SURFAC	E	D	DESCRIPTION OF SERVICE		
REMARK	S:							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						ABCDE FGHIJ TSRQP ONMLK		
SUBSCRIBER AUTHORIZATIONS:						ADDITIONAL INFORMATION		
I hereby	certify that the o	dated procedur	es have b	een complete	ed.	Dadiagraphs analosad?		
						Radiographs enclosed? Is treatment for orthodontics? Yes or No		
Please issue payment directly to the dentist or dental entity below.						Date of insertion? Replacement of prosthesis? Date of prior placement?		
BILLING DENTIST OR DENTAL ENTITY (Name and address)						TREATING DENTIST I certify that the dated procedures on the claim form have been completed.		
						Treating Dentist Signature		
NPI		License Numb	er	TIN or SSN				
Dhana Number						Date License		
Phone Number						NPI	License	

