RETURN TO:
SELF-INSURED DENTAL SERVICES
Dept 15
PO Box 9005
Lynbrook, NY 11563-9005
(516)396-5500 / (718)204-7172
www.asonet.com

Dental Claim Form

PLEASE CHECK APPROPRIATE BOX TO INDICATE MEMBER STATUS

- ☐ **CSA WELFARE FUND**
- ☐ **CSA RETIREE WELFARE FUND**
- ☐ **DCC/CSA WELFARE FUND (Day Care)**

☐ **PRE-TREATMENT ESTIMATE**
(REQUIRED FOR INLAYS, CROWNS, LAMINATE VENEERS, BRIDGES, DENTURES, PERIODONTAL SURGERY, OR WHEN EXPENSES WILL EXCEED $300 IN A 90 DAY PERIOD)

☐ **PAYMENT CLAIM**

PLEASE SUBMIT PRE-OPERATIVE PERIAPICAL X-RAYS FOR INLAYS, CROWNS, BRIDGES, DENTURES, PERIO SURGERY, ROOT THERAPY AND NON-ROUTINE EXTRACTIONS. X-RAYS OF FULL ARCH REQUIRED FOR ALL BRIDGE WORK. POST TREATMENT X-RAYS REQUIRED FOR ALL ROOT THERAPY CLAIMS.

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR MEMBERS, SPOUSES, AND DEPENDENTS)

Patient Name	Birth date	Relationship to Member Member ☐ Spouse ☐ Child ☐ Other	If Full Time College Student: School, City

MEMBER INFORMATION *(REQUIRED ON ALL CLAIMS)*

(You may indicate only the last 4 digits)

Member Name	Birth date	Sex	Social Security # ☐☐☐ - ☐☐ - ☐☐☐☐

Home Address	City	State	Zip	Telephone# ( )

Work Location	Work Telephone #	Check Type of Medical Coverage You have Selected H.I.P/HMO ☐ G.H.I. Type C ☐ G.H.I. - CBP ☐ OTHER ☐	Are you covered for dental benefits by any other group plan or government agency? Yes ☐ No ☐

Name of Other Company/Organization Providing Benefits	Policy/Plan Number	Start date: / /

SPOUSE INFORMATION *(REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)*

Spouse's Name	Spouse's Birth date	Spouse's Social Security #	Is spouse covered by another Dental Benefits Plan? Yes ☐ No ☐

Name, Address, Telephone # of Spouse's Employer ***(MUST BE COMPLETED OR CLAIM WILL BE RETURNED)***

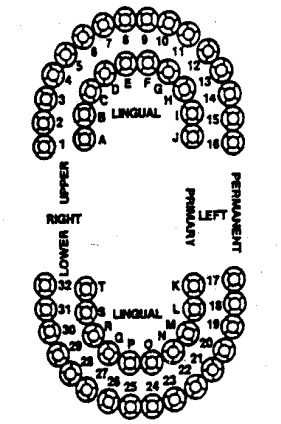
DENTIST INFORMATION *(TO AVOID DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, PRIMARY VOUCHERS, ETC.)*

Dentist's Name (Print)	License #	Telephone #	Taxpayer ID#

Street Address	City	State	Zip Code

If Prosthesis, is this initial placement? Yes ☐ No ☐	Date of Prior Placement	Reason for Replacement	**IS THIS CLAIM THE RESULT OF:**	Accident Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

DENOTE MISSING TEETH WITH AN "X"



PLEASE CHART PROPOSED OR RENDERED TREATMENT

Date Service Performed	Tooth # or Letter	Surface	ADA CODE	Description of Service (including radiographs, prophylaxis, materials used, etc.)	Fee

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

TOTAL FEE CHARGED

I hereby certify the accuracy of the procedures and dates of completion as listed above.

Signed (Dentist) _____ **Date** _____

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any insurance company, prepayment organization, employer, hospital, or dentist, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the information submitted by me in support of this claim is true and correct. ***Authorization must be signed or payment will not be made.***

Patient Signature (or member or spouse if patient is a minor) _____ **Date** _____

ASSIGNMENT OF BENEFITS: *I hereby authorize payment of the benefits (otherwise payable to me) directly to the above named dentist. I understand I am financially responsible to the dentist for charges not covered by this authorization.*

Patient Signature (or member or spouse if patient is a minor) _____ **Date** _____

You may photocopy this claim form or use universal claim forms. Please feel free to access our website at www.asonet.com