

**CSEA EMPLOYEE BENEFIT FUND**

**DENTAL CLAIM FORM**

<p>◇ Statement of Actual Completed Services</p> <p>◇ Pretreatment Estimate/Predetermination</p>	SUBSCRIBER NAME (Last, First, Middle Initial) ADDRESS	
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<p><b>SEND CLAIM FORM TO:</b></p> <p><b>CSEA EMPLOYEE BENEFIT FUND</b>  <b>PO BOX 489</b>  <b>LATHAM, NY 12110-0489</b></p> <p><b>PHONE NUMBER: (800) 323-2732</b></p>	Date of Birth (mm/dd/ccyy) Gender (please circle)	
	M F	
	SUBSCRIBER ID NUMBER	
PATIENT NAME (Last, First, Middle Initial)		

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	PROCEDURE CODE	TOOTH #/ LETTER / QUAD	SURFACE	DESCRIPTION OF SERVICE	FEE

REMARKS:	TOTAL
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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

<p><b>SUBSCRIBER AUTHORIZATIONS:</b></p> <p>I hereby certify that the dated procedures have been completed.</p> <hr/> <p>Please issue payment directly to the dentist or dental entity below.</p> <hr/>	<p><b>ADDITIONAL INFORMATION</b></p> <p>Radiographs enclosed? _____</p> <p>Is treatment for orthodontics? Yes or No</p> <p>Date of insertion? _____</p> <p>Replacement of prosthesis? Yes or No</p> <p>Date of prior placement? _____</p>
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<b>BILLING DENTIST OR DENTAL ENTITY (Name and address)</b>  	<b>TREATING DENTIST</b> I certify that the dated procedures on the claim form have been completed.
	<p>_____</p> <p style="text-align: center;">Treating Dentist Signature</p>

NPI	License Number	TIN or SSN
Date		

Phone Number	NPI	License
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