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<br>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#<br>( ) |
|---|---|---|---|---|
| | | | | |

| Work Location | Work Telephone # | Check Type of Medical Coverage You have Selected<br>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:<br>/ / |
|---|---|---|
| | | |

## 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?<br>Yes ☐ No ☐ |
|---|---|---|---|
| | | | |

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

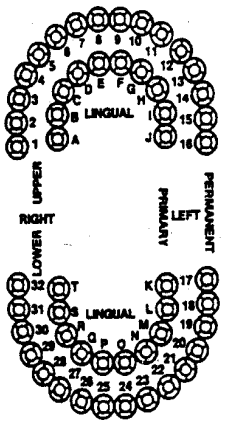
## DENTIST INFORMATION *(TO AVOID DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, PRIMARY VOUCHERS, ETC.)*

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

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

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