Reason for submission (Please ✓ one):

☐ Statement of Actual Completed Services

☐ Pretreatment Estimate/Predetermination

DENTAL CLAIM FORM

www.cseaebf.com 800-323-2732

Claim Address: PO Box 489 Latham NY 12110-0489

CSEA EMPLOYEE BENEFIT FUND

SUBSCRIBER INFORMATION

Subscriber's Name_____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy)_____

☐ Male ☐ Female (Check one)

Subscriber's EBF ID Number_____

Street Address_____

City_____State_____Zip_____

PATIENT INFORMATION

Patient's Name_____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy)_____

☐ Male ☐ Female (Check one)

Relationship to Subscriber (Check one)

☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

OTHER COVERAGE INFORMATION

Is other Dental coverage available? (Check one) ☐ Yes ☐ No

Name of Company_____

Other Dental Company Claim Address_____

_____

_____

_____

City_____State_____Zip_____

Subscriber's Name_____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy)_____

☐ Male ☐ Female (Check one)

Subscriber's ID Number_____

Plan/Group Number_____

Patient Relationship to Subscriber (Check one)

☐ Self ☐ Spouse ☐ Dependent Child ☐ 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	A	B	C	D	E
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	T	S	R	Q	P

SUBSCRIBER AUTHORIZATION

I hereby certify that the dated procedures have been completed.

X

Please issue payment directly to the dental entity below.

X

ADDITIONAL INFORMATION

Radiographs enclosed? (Yes/No)_____

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)

NPI	License #	TIN or SSN

Phone Number

TREATING DENTIST

Treating Dentist Sign Below

X

Date (mm/dd/yyyy)_____

NPI	License #