CSEA
AFSCME Local 1000, AFL-CIO
EMPLOYEE BENEFIT FUND

DENTAL CLAIM FORM

NOTE:
- SEE REVERSE SIDE FOR COMPLETE FILING INSTRUCTIONS.
- MAIL CLAIMS TO: CSEA EBF, P.O. BOX 489, LATHAM, NY 12110-0489.
- SUBMIT THIS CLAIM FORM FOR PAYMENT AFTER **ALL** DENTAL WORK IS COMPLETED.
- **EMPLOYEE FILL IN AREAS PRINTED IN RED** — DENTIST TO COMPLETE THE BALANCE.

CHECK ONE: ❑ DENTIST'S PRE-TREATMENT ESTIMATE ❑ DENTIST'S STATEMENT OF ACTUAL SERVICES

PART 1

PATIENT NAME | RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER | SEX: M | F | PATIENT BIRTHDATE: MO | DAY | YEAR

EMPLOYEE FIRST | MIDDLE | LAST

EMPLOYEE SOCIAL SECURITY NO.

EMPLOYEE MAILING ADDRESS

WORK PHONE ( )

CITY | STATE | ZIP

HOME PHONE ( )

IF FULL TIME STUDENT - SEE REVERSE

DOES PATIENT HAVE OTHER DENTAL COVERAGE? ❑ YES ❑ NO IF YES– IDENTIFY OTHER COVERAGE

PART 2

Enter The Taxpayer Identifying Number To Be Used For 1099 Reporting Purposes

Enter Exact Name Associated With Taxpayer ID Above

Enter Dentist License Number Associated With Taxpayer ID Above

Mailing Address

Phone No.

Is Treatment For Orthodontics?	If Services Already Commenced,	Enter Date Appliances Placed	Enter # of Mos Treatment Has Been In Progress

PART 3

PLEASE ISSUE PAYMENT DIRECTLY TO THE DENTIST

SIGNED (COVERED EMPLOYEE)

DENTAL PRACTICE LIMITED TO: (CHECK APPROPRIATE BOX)
❑ GENERAL PRACTICE ❑ ORTHODONTIA ❑ PERIODONTIA
❑ ORAL SURGERY ❑ ENDODONTIA

IF PROTHESIS, IS THIS INITIAL PLACEMENT ❑ YES ❑ NO
IF NO ENTER DATE OF PRIOR PLACEMENT

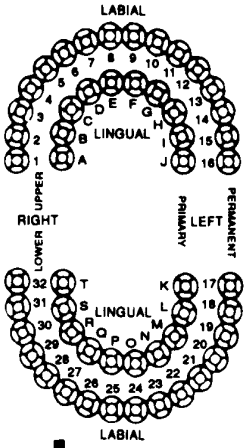
RADIOGRAPHS ENCLOSED ❑ YES ❑ NO ❑ F.M.S. ❑ PANOREX BITEWINGS _____ HOW MANY PERIAPICALS _____ HOW MANY

PART 4

EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				
		16				
		17				
		18				
		19				
		20				
				TOTAL FEE CHARGED		

INDICATE MISSING TEETH WITH AN "X"



PART 5

NOT TO BE SIGNED BY MEMBER UNTIL WORK IS COMPLETED

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED TO MY SATISFACTION

EMPLOYEE SIGNATURE _____

DATE _____

PART 6

INDICATE NO.

DENTIST CERTIFICATION FOR SERVICES PROVIDED

I certify that the above number of _____ items were provided and completed by me.

Dentist Signature _____ Date _____

Instructions for filing a dental claim:

1. Employee fills out Part 1 of claim form and signs Part 5 after **dental treatment is completed.**

2. Dentist fills out Parts 2 and 4 of claim form and signs Part 6 upon completion of a course of dental treatment.

3. Employee/Dentist mails claim to **CSEA Employee Benefit Fund, P.O. Box 489, Latham, N.Y. 12110-0489.** Phone (518) 782-1500 / 1-800-323-2732.

4. Claims should be submitted within 30 days of work completion.

5. **Pre-Determination of Benefits** is required for dental services anticipated to be **in excess of $250.00.**

   The same form may be used when applying for Pre-Determination.

   Reminder: Claim cannot be processed for payment unless you sign **Part 5.**

DEPENDENT STUDENT COVERAGE

An unmarried child who is a full-time student will be covered up to age 25 (12 hours enrolled for undergraduate credits or 6 hours graduate credits). Proof of student status must be submitted to the Fund annually before a claim can be honored. Such proof consists of a letter from the college or university attesting to his/her full-time attendance during the period that dental services were performed. If this proof has already been recorded with the Fund, it is not necessary to resubmit it with this claim.