**RETURN TO:**
Self-Insured Dental Services
Department 4
P O Box 9005
Lynbrook, NY 11563
(516) 396-5500
www.asonet.com

# SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION WELFARE FUND DENTAL CLAIM

☐ **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 X-RAYS FOR INLAYS, CROWNS, BRIDGES, DENTURES, PERIO SURGERY, ROOT THERAPY AND NON-ROUTINE EXTRACTIONS IF NOT PRE-DETERMINED. POST TREATMENT X-RAYS REQUIRED FOR ALL ROOT THERAPY CLAIMS.

**PATIENT INFORMATION** *(REQUIRED ON ALL CLAIMS )*

| Patient Name | Birth date | Relationship to Member Spouse ☐ Child ☐ | Full Time College Student Yes ☐ No ☐ | **If over 19, student verification is required each semester and must be on file with the Benefit Fund.** |
|---|---|---|---|---|
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**MEMBER INFORMATION** *(REQUIRED ON ALL CLAIMS)*

| Member Name | Birth Date | Sex | Social Security# |
|---|---|---|---|
| | | | |

| Street Address | City | State | Zip | Telephone# |
|---|---|---|---|---|
| | | | | ( ) |

**SPOUSE INFORMATION** *(REQUIRED ON ALL CLAIMS )*

| Spouse's Name | Spouse's Birth Date | Spouse's Social Sec. # | Is spouse covered by another Dental Benefits Plan? ☐ Yes ☐ No |
|---|---|---|---|
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Name of Spouse's Employer ***(MUST BE COMPLETED OR CLAIM WILL BE RETURNED)***

**IS THERE ANY OTHER COVERAGE THAT MAY PAY ANY PART OF THIS CLAIM? YES ☐ NO ☐**

| Insured's Name | Social Security # | Carrier and policy number |
|---|---|---|
| | | |

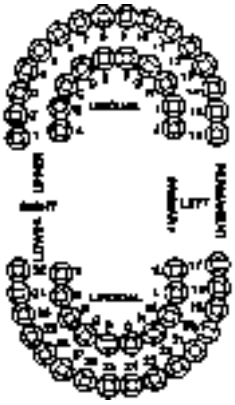
**DENTIST INFORMATION** *(TO AVOID DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, PRIMARY VOUCHERS, ETC.)*

| 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 of Service | 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.*

**Signed** (Member) **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.*

**Signed** (Member) **Date**