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, INC.
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)

OR

☐ **PAYMENT CLAIM** PLEASE SUBMIT PRE-OPERATIVE X-RAYS FOR INLAYS, CROWNS, BRIDGES, DENTURES, PERIODONTAL 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	Full-Time College Student?	If over 19 years old, student verification is required each semester and must be on file with the Benefit Fund.
		☐ Self ☐ Spouse ☐ Child	☐ Yes ☐ No	

MEMBER INFORMATION (REQUIRED ON ALL CLAIMS)

Member Name	Birth Date	Sex	Member's Social Security Number

Street Address	City	State	ZIP Code	Telephone #

SPOUSE INFORMATION, IF MARRIED (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

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 IF YES, COMPLETE BELOW

Insured's Name	Social Security #	Insurance Carrier and Policy Number

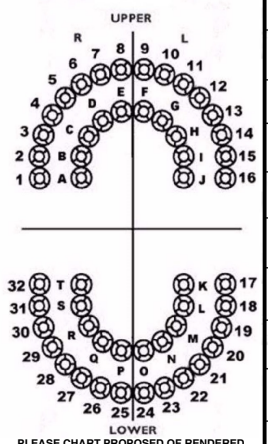
DENTIST INFORMATION (TO AVOID DELAY, BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, PRIMARY VOUCHERS, ETC.)

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 OF RENDERED TREATMENT

DATE OF SERVICE	TOOTH # OR LETTER	SURFACE	ADA CODE	DESCRIPTION OF SERVICE (including radiographs, prophylaxis, materials used, etc.)	FEE

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 the payment of the benefits (otherwise payable to me) directly to the above-named dentist. I understand that I am financially responsible to the dentist for charges not covered by this authorization.*

Signed (Member) _____ **Date** _____