

PORT CHESTER TEACHERS ASSOCIATION WELFARE TRUST FUND DENTAL CLAIM FORM

RETURN TO:

Self-Insured Dental Services
Department 28-D
PO Box 9005
Lynbrook, NY 11563
(516) 396-5500 / (718) 204-7172
www.asonet.com

PRE-TREATMENT ESTIMATE
(REQUIRED FOR INLAYS, CROWNS, LAMINATE VENEERS,
BRIDGES, DENTURES, PERIODONTAL SURGERY, OR WHEN
EXPENSES WILL EXCEED \$300 IN A 90 DAY PERIOD)

PLEASE SUBMIT PRE-OPERATIVE 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.

PAYMENT CLAIM

PATIENT INFORMATION (REQUIRED ON ALL CLAIMS)

Patient Name	Birth date	Relationship to Member Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Full Time College Student Yes <input type="checkbox"/> No <input type="checkbox"/>	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 Security #	Is spouse covered by another Dental Benefits Plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Prior Placement	Reason for Replacement	IS THIS CLAIM THE RESULT OF: Accident Injury? Yes <input type="checkbox"/> No <input type="checkbox"/> Occupational Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>

DENOTE MISSING TEETH WITH AN "X"	Tooth # or Letter	Surface	Description of Service (including radiographs, prophylaxis, materials used, etc.)	Date Service Performed	Procedure Number	Fee	
<p>PLEASE CHART PROPOSED OR RENDERED TREATMENT</p>							

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.

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.

Signed (Member) SIGNATURE ON FILE IS NOT ACCEPTABLE _____
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) SIGNATURE ON FILE IS NOT ACCEPTABLE _____
Date