RETURN TO:
Administrative Services Only
P.O. Box 9005 Dept. 32
Lynbrook, NY 11563

Self-Insured Dental Services
(516) 396-5500 www.asonet.com

FARMINGDALE FEDERATION OF TEACHERS BENEFIT 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	Full Time College Student	
		Spouse ☐ Child ☐	Yes ☐ No ☐	**If over 19, student verification is required each semester and must be on file with the Benefit Fund.**

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

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

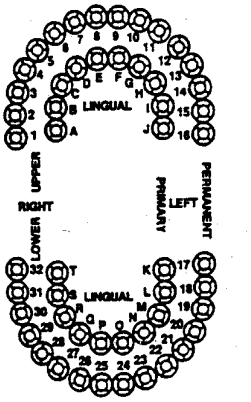
DENTIST INFORMATION *(TO AVOID DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, PRIMARY VOUCHERS, ETC.)*

Dentist's Name (Print)	License #	Telephone #	Taxpayer ID#

Street Address	City	State	Zip Code

If Prosthesis, is this initial placement?	Date of Prior Placement	Reason for Replacement	**IS THIS CLAIM THE RESULT OF:**
Yes ☐ No ☐			Accident Injury? Yes ☐ No ☐ Occupational Injury? Yes ☐ No ☐

DENOTE MISSING TEETH WITH AN "X"



PLEASE CHART PROPOSED OR RENDERED TREATMENT

Tooth # or Letter	Surface	Description of Service (including radiographs, prophylaxis, materials used, etc.	Date Service Performed	Procedure Number	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. **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**

GROUP	**FOR OFFICE USE ONLY:** We certify that the patient as indicated above is covered by our group contract and is eligible for benefits.	Date Eligible	Type of Contract ☐Active ☐Retired	By	Date