## RETURNTO:

Patient Name

Member Name

Street Address

Spouse's Name

Self-Insured Dental Svcs Dept. 67 PO Box 9005 Lynbrook, NY 11563 (516) 396-5500 www.asonet.com

PATIENT INFORMATION

**MEMBER INFORMATION** 

SPOUSE INFORMATION

**DENTIST INFORMATION** 

If Prosthesis, is this initial placement?

DENOTE MISSING TEETH WITH AN "X"

PLEASE CHART PROPOSED OR RENDERED TREATMENT Date

Service

No 🗌

Dentist's Name (Print)

Street Address

Yes

## **GENERAL BUILDING LABORERS' LOCAL UNION NO.66** WELFARE FUND

**DENTAL BENEFIT CLAIM FORM** PLEASE SUBMIT PRE-OPERATIVE X-RAYS FOR INLAYS, PRE-TREATMENT ESTIMATE CROWNS, BRIDGES, DENTURES, PERIO SURGERY, ROOT (REQUIRED FOR INLAYS, CROWNS, LAMINATE VENEERS, THERAPY AND NON-ROUTINE EXTRACTIONS. X-RAYS OF BRIDGES, DENTURES, PERIODONTAL SURGERY, OR WHEN FULL ARCH REQUIRED FOR ALL BRIDGE WORK, POST EXPENSES WILL EXCEED \$300 IN A 90 DAY PERIOD) TREATMENT X-RAYS REQUIRED FOR ALL ROOT THERAPY CLAIMS **PAYMENT CLAIM** (REQUIRED ON ALL CLAIMS ) Birth date Relationship to Member Full Time College Student If over 19, student verification is required each semester. Spouse Child Yes No (REQUIRED ON ALL CLAIMS) Birth date Sex Social Security# City State Name of Other Company/Organization Providing Benefits Start date: Policy/Plan Number (REQUIRED ON ALL CLAIMS) Spouse's Birth date Spouse's Social Security # Is spouse covered by another Dental Benefits Plan? Yes No Name, Address, Telephone # of Spouse's Employer (MUST BE COMPLETED OR CLAIM WILL BE RETURNED) (TO AVOID DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, PRIMARY VOUCHERS, ETC.) License# Telephone# Taxpayer!D# Zip Code City State Date of Prior Placement Reason for Replacement IS THIS CLAIM THE RESULT OF: Accident Injury? No □ No Occupational Injury? Yes Description of Service Tooth# ADA Surface (including radiographs, prophylaxis. materials used, etc.) Letter Performed ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM TOTAL FEE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING CHARGED 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. 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. Date

Date

Signed (Member)

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)

Signed (Dentist)