RETURNTO:

Patient Name

Member Name

Street Address

Spouse's Name

Dentist's Name (Print)

If Prosthesis, is this initial placement?

DENOTE MISSING TEETH WITH AN "X

PLEASE CHART PROPOSED OR RENDERED TREATMENT

Signed (Dentist)

Signed (Member)

No \square

Street Address

Self-Insured Dental Services Department 7 P O Box 9005 Lynbrook, NY 11563-9005 516-396-5500/ 800-537-1238 www.asonet.com

PATIENT'S INFORMATION

MEMBER'S INFORMATION

SPOUSE'S INFORMATION

I.A.T.S.E. NATIONAL HEALTH AND WELFARE FUND

DENTAL CLAIM FORM

FOR ALL ELIGIBLE MEMBERS PRE-TREATMENT ESTIMATE PLEASE SUBMIT PRE-OPERATIVE PERIAPICAL X-RAYS FOR (RECOMMENDED FOR INLAYS, CROWNS, LAMINATE INLAYS, CROWNS, BRIDGES, DENTURES, PERIO SURGERY VENEERS, BRIDGES, DENTURES, PERIODONTAL SURGERY ROOT THERAPY AND NON-ROLITINE EXTRACTIONS, X-RAYS OR WHEN EXPENSES WILL EXCEED \$250 IN A 90 DAY PERIOD) OF FULL ARCH REQUIRED FOR ALL BRIDGE WORK. POST TREATMENT X-RAYS REQUIRED FOR ALL ROOT THERAPY **PAYMENT CLAIM** CLAIMS (REQUIRED ON ALL CLAIMS) 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. Birth date (REQUIRED ON ALL CLAIMS) Birth date Social Security# Sex City State Zip Telephone# (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) Start Date: Name of other Company/Organization Providing Benefits DENTIST INFORMATION (TO AVOID DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, PRIMARY VOUCHERS, ETC.) Telephone# Taxpayer ID# City State Zip Code Are radiographs enclosed? If yes, how many? IS THIS CLAIM THE RESULT OF: Accident Injury? Date of Prior Placement No 🔲 Occupational Injury? Yes Date Tooth a Description of Service Procedure Surface (including radiographs, prophylaxis, Service Fee Number Performed Letter materials used, etc. 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 ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME. CHARGED I hereby certify the accuracy of the procedures and dates of completion as listed above. Date

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)	Date
	OF BENEFITS: I hereby authorize payment of the benefits (otherwise payable to me) directly to the above named dentist am financially responsible to the dentist for charges not covered by this authorization.

DENTAL CLAIM INSTRUCTIONS

BEFORE BEGINNING TREATMENT

Pre-certification gives you and your dentist a better understanding of the Plan's covered expenses and allows for the resolution of questions before your treatment begins.

Pre-certification is recommended if the course of treatment prescribed is expected to cost more than \$250 in a 90 day period and/or includes any of the following services: crowns, bridges, dentures, laminate veneers or periodontal surgery.

The pre-certification procedure requires that your dentist submit a claim form showing the proposed course of treatment and the fees for each procedure. Be sure that your dentist includes the patient's x-rays. This will reduce the time that it takes Self-Insured Dental Services to process the pre-certification request. The proposed treatment plan together with the x-rays should be sent to Self-Insured Dental Services.

Self-Insured Dental Services will review the treatment plan and the patient and the dentist will receive a precertification form indicating the benefits which will be payable for each dental service according to the terms of our program and which services, if any, are not covered. When the treatment is completed, your dentist must insert the dates that the authorized services were performed and then resubmit the pre-certification form to Self-Insured Dental Services.

HOW TO FILE A CLAIM

After the dental work has been performed, complete the dental form, whether or not pre-certification was previously submitted.

- 1. Have your Dentist complete the Dentist's Statement. If pre-certification has been already authorized, have the dentist fill in dates of service.
- 2. Complete, date and sign the dental form.

After the initial claim submission, a separate dental form will be required for all subsequent claim submissions for each family member.

The benefits to which you are entitled will be paid to you unless you have assigned them. If you assign benefits, you will be notified of the payments made, so that you will know the portion of the bill not covered by the Dental Plan. You are financially responsible to the dentist for charges not covered by the Plan.

WHEN TO FILE A CLAIM

Upon completion of treatment (or during treatment if dentist bills are received at intervals), submit a completed dental form no later than 180 days from the date of service. Failure to comply with this will jeopordize your benefit payment.

WHERE TO FILE A CLAIM

Send the completed dental form to Self-Insured Dental Services, 71 South Central Avenue, Valley Stream, New York, 11582. Be sure that your Dentist's Statement has been completed and signed. If you have any questions regarding your claim, please contact Self-Insured Dental Services at

(516) 396-5500 or (800) 537-1238