Dental Claim Form

☐ Dentist's pre-treatment estimate — Specialty (see backside)
☐ Dentist's statement of actual services
☐ Medicaid Claim — Prior Authorization #
☐ EPSDT

MAIL COMPLETED FORM TO:
New York Court Clerks Association
Security Benefits Fund
c/o Daniel H. Cook Associates
253 West 35th Street -12th Floor
New York, NY 10001-1907
(212) 505-5050

PATIENT

Patient Name (Last, First, Middle)	* Address	City	State

Date of Birth (MM/DD/YYYY)	Patient ID #	Sex	Phone Number	Zip Code
/ /		☐M ☐F	( )	

Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other_____

Employer/School Name_____ Address_____

SUBSCRIBER / EMPLOYEE

Subs /Emp. ID#/SSN#	Employer Name	Group #

Subscriber/Employee Name (Last, First, Middle)

Address	Phone Number
	( )

City	State	Zip Code

Date of Birth (MM/DD/YYYY)	Marital Status	Sex
/ /	☐Married ☐Single ☐Other	☐M ☐F

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical — Policy #

Other Subscriber's Name

Date of Birth (MM/DD/YYYY)	Sex	Plan/Program Name
/ /	☐M ☐F	

Employer/School Name_____ Address_____

Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

Employer/School Name_____ Address_____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

Name of Billing Dentist or Dental Entity	Phone Number	Provider ID #	Dentist Soc. Sec. or T.I.N
	( )		

Address	Dentist License #	First visit date of current series:	Place of treatment
			☐Office ☐Hosp. ☐ECF ☐Other

City	State	Zip Code	Radiographs or models enclosed?
			☐Yes, How many?_____ ☐No

Is treatment for orthodontics? ☐Yes ☐No
If service already commenced:
Date appliances placed _____ Total mos. of treatment remaining _____

If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: _____ Date of prior placement: _____

Is treatment result of occupational illness or injury? ☐No ☐ Yes
Brief description and dates_____

Is treatment result of: ☐auto accident? ☐other accident? ☐neither
Brief description and dates_____

Diagnosis Code Index (optional)
1 _____ 2. _____ 3. _____ 4. _____ 5 _____ 6 _____ 7. _____ 8. _____

Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

Identify all missing teeth with "X"

Permanent								Primary							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Remarks for unusual services

I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

Address where treatment was performed

City	State	Zip Code

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Relationship to Subscriber/Employee
☐Self ☐Spouse ☐Child ☐Other_____

Employer/School
Name_____ Address_____

SUBSCRIBER / EMPLOYEE

Subs /Emp. ID#/SSN#	Employer Name	Group #

Subscriber/Employee Name (Last, First, Middle)

Address	Phone Number
	( )

City	State	Zip Code

Date of Birth (MM/DD/YYYY)	Marital Status	Sex
/ /	☐Married ☐Single ☐Other	☐M ☐F

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X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

Is Patient covered by another plan	Policy #
☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical	

Other Subscriber's Name

Date of Birth (MM/DD/YYYY)	Sex	Plan/Program Name
/ /	☐M ☐F	

Employer/School
Name_____ Address_____

Subscriber/Employee Status
☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

Employer/School
Name_____ Address_____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

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	( )		

Address	Dentist License #	First visit date of current series:	Place of treatment
			☐Office ☐Hosp. ☐ECF ☐Other

City	State	Zip Code

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32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Remarks for unusual services

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
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X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

Address where treatment was performed

City	State	Zip Code

THIS FORM WILL BE RETURNED IF IT IS INCOMPLETE OR INCORRECT

NOTICE TO MEMBERS

- **PRE-AUTHORIZATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $500 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-AUTHORIZATION.** Pre-authorization by the Fund's Dental Consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, the patient's eligibility or guaranteed payment.
- CLAIM MUST BE SUBMITTED WITHIN 180 DAYS AFTER COMPLETION OF COURSE OF DENTAL TREATMENT.
- Bring a claim form with you when you visit your dentist. Complete your part - give all the information required. DISCUSS FEES BEFORE SERVICES ARE PERFORMED. If you have any questions about your dental benefits, contact the Dental Program Administrator.
- A covered patient may go to any dentist, anywhere, and the amount of payment is the same regardless of the dentist chosen.
- Mail this form to: **New York State Court Clerks Association**
  Security Benefits Fund
  c/o Daniel H. Cook Associates
  253 West 35th Street 12th Floor
  New York, NY 10001 -1907 Telephone (212) 505-5050

NOTICE TO DENTISTS

- **There is no assignment of benefits under this dental program unless you are a participating provider.**
- Pre-Treatment Authorization must be filed not later than 30 days after examination.
- If services rendered are for emergency treatment or due to an accidental injury, Pre-Authorization will not be necessary.
- **PRE-AUTHORIZATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $500 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-AUTHORIZATION.** Pre-Authorization by the Fund's Dental Consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, the patient's eligibility or guaranteed payment. Completed treatment amounting to $1,000 or more may require examination of patient by Fund's Consultant Dentist before payment is made.
- **All procedures must have corresponding CDT/ADA procedure codes listed in order to be processed.**

FUND DENTAL CONSULTANT REMARKS:

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ANYONE INTENTIONALLY MISUSING THIS FORM FOR THE PURPOSE OF OBTAINING IMPROPER PAYMENTS IS SUBJECT TO APPROPRIATE ACTION.