RETURN TO:
Administrative Services Only, Inc.
P.O. Box 9005, Dept. 118
Lynbrook, NY 11563-9005
(516) 396-5500
www.asonet.com
Benefit Information
Claim Forms
Claim Inquiries

BETHPAGE CONGRESS OF TEACHERS BENEFIT TRUST FUND
Dental Claim Form

☐ **CHECK THIS BOX FOR PRE-TREATMENT ESTIMATE**
(RECOMMENDED FOR ORTHODONTIA, INLAYS, CROWNS, LAMINATE VENEERS, BRIDGES, DENTURES, PERIODONTAL SURGERY, OR WHEN EXPENSES WILL EXCEED $500 IN A 90 DAY PERIOD)

PLEASE SUBMIT PRE-OPERATIVE X-RAYS FOR ORTHODONTIA, 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)* **(If over 19, student verification is required each semester and must be on file with the Benefit Fund.)**

Patient Name	Birth date	Relationship to Member	Full Time College Student
		Self ☐ Spouse ☐ Child ☐	Yes ☐ No ☐

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/Name	Birth Date	Social Sec. #	Is spouse covered by another Dental Benefits Plan?
			☐ Yes ☐ No

Name of Spouses' 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

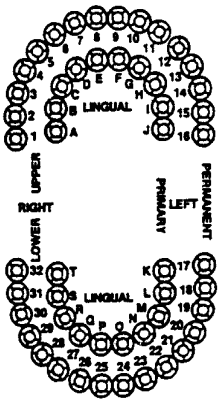
DENTIST INFORMATION *(TO AVOID DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, EOB FROM PRIMARY CARRIER, ETC.)*

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 THIS 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: Authorization must be signed or payment will not be made.
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.

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**