## **RETURNTO:**

## GENERAL BUILDING LABORERS' LOCAL UNION NO.66 WELFARE FUND DENTAL BENEFIT CLAIM FORM

Self-Insured Dental Svcs D PO Box 9005 Lynbrook, NY 11563 (516) 396-5500 www.asonet.com	nbrook, NY 11563 16) 396-5500				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. X-RAYS OF FULL ARCH REQUIRED FOR ALL BRIDGE WORK. POST TREATMENT X-RAYS REQUIRED FOR ALL ROOT THERAPY CLAIMS.				
PATIENT INFORMATION (	REQUIRE	D ON A	ALL CLA	IMS)											
Patient Name		Birth da	Relationship t	elationship to Member   Full Time College Studer   Spouse   Child   Yes   No				If over 19, student verification is required each semester.							
MEMBERINFORMATION (	REQUIRE	D ON A	LL CLAI	MS)											
Member Name	Name				Birth date Se				Social Security#						
StreetAddress					ity			State	Zip						
Name of Other Company/Organization Providing Benefits									Policy/Plan Number Startdate:						
SPOUSE INFORMATION (REQUIRED ON ALL CLAIMS)															
Spouse's Name	S	Spouse's Birt	Spouse's So	pouse's Social Security# Is spouse c				overed by another Dental Benefits Plan? Yes No							
Name, Address, Telephone # of Spouse's Employer (MUST BE COMPLETED OR CLAIM WILL BE RETURNED)															
DENTIST INFORMATION (	ΤΟ ΑΥΟΙΕ	DELAY	/ BE SU	RE TO E	NCLOSE	X-RA	YS,	PERIO	CHART	ING, PRIM	ARY VO	UCHE	RS, ETC.)		
Dentist's Name (Print)	License#				Telephone#				TaxpayerID#						
Street Address				City					State		Zip Code				
If Prosthesis, is this initial placement? Yes No	Date of Prior P	Placement	Reasonfor	Replacement			IS	THIS CLAIN	THE RES		Accident Injury Occupational In				
DENOTE MISSING TEETH WITH AN "X"	Date Service Performed	Tooth# or Letter	Surface	ADA CODE		Description of Service (including radiographs, prophylaxis, materials used, etc.)  Fee					Fee				
D 1 D A 1 D 16 D PERMANENT IN THE PROPERTY IN															
PLEASE CHART PROPOSED OR RENDERED TREATMENT															
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSI CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE A					THE PURPOSE OF MISLEADING, INFORMATIO						TOTAL FEE CHARGED				
Signed (Dentist)  AUTHORIZATION TO RELEAS I hereby authorize any insuran or any of my dependents which the information submitted by re	SEINFORM ce compar h may have	IATION: ny, prepa e a bearii	yment or ng on the	ganization,	employer,	, hospi	– ital,	or dentis	Date t, to relea						
Signed (Member)							_		Date			_			
ASSIGNMENT OF BENEFITS I understand I am financially r									ne) direc	tly to the at	oove name	d denti	st.		
Signed (Member)							-	-	Date			-			