

Reason for submission (Please one):

- Statement of Actual Completed Services
- Pretreatment Estimate/Predetermination

DENTAL CLAIM FORM

www.cseabf.com 800-323-2732

Claim Address: PO Box 489 Latham NY 12110-0489



SUBSCRIBER INFORMATION

PATIENT INFORMATION

Subscriber's Name _____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy) _____

Male Female (Check one)

Subscriber's EBF ID Number _____

Street Address _____

City _____ State _____ Zip _____

Patient's Name _____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy) _____

Male Female (Check one)

Relationship to Subscriber (Check one)

Self Spouse Dependent Child Other

OTHER COVERAGE INFORMATION

Is other Dental coverage available? (Check one) Yes No

Name of Company _____

Other Dental Company Claim Address _____

City _____ State _____ Zip _____

Subscriber's Name _____
First Name, Middle, Last Name

Date of Birth (mm/dd/yyyy) _____

Male Female (Check one)

Subscriber's ID Number _____

Plan/Group Number _____

Patient Relationship to Subscriber (Check one)

Self Spouse Dependent Child Other

RECORD OF SERVICES PROVIDED

Date of Service	Procedure Code	Tooth #/ Letter/Quad	Surface	Description of Service	Fee

Remarks: _____ Total

**Missing Teeth
(Mark each missing
tooth with an X.)**

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A	B	C	D	E	F	G	H	I	J
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T	S	R	Q	P	O	N	M	L	K
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SUBSCRIBER AUTHORIZATION

ADDITIONAL INFORMATION

I hereby certify that the dated procedures have been completed.

Please issue payment directly to the dental entity below.

Radiographs enclosed? (Yes/No) _____

Is treatment for orthodontics? (Yes/No) _____

Date of insertion? (dd/mm/yyyy) _____

Replacement of prosthesis (Yes/No) _____

Date of prior placement? (dd/mm/yyyy) _____

BILLING DENTIST OR DENTAL ENTITY (NAME AND ADDRESS)

TREATING DENTIST

NPI _____ License # _____ TIN or SSN _____

Phone Number _____

Treating Dentist Sign Below

Date (mm/dd/yyyy) _____

NPI _____ License # _____