RETURN TO:
ADMINISTRATIVE SERVICES ONLY, INC.
Self Insured Dental Services (SIDS)
PO Box 9005
Lynbrook, NY 11563

(516) 396-5500 / (718) 204-7172

ASSISTANT DEPUTY WARDENS
DEPUTY WARDENS ASSOCIATION

☐ ACTIVE ☐ RETIREE

DENTAL CLAIM FORM

☐ **PRE-TREATMENT ESTIMATE**
(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 *(REQUIRED ON ALL CLAIMS)*

Patient Name:	Birthdate:	Social Security #: (Last 4 digits) X X X - X X - _____	Relationship to Member: Self ☐ Spouse ☐ Child ☐

MEMBER/EMPLOYEE INFORMATION *(REQUIRED ON ALL CLAIMS)*

Member Name:	Birth Date:	Social Security #: (Last 4 digits) X X X - X X - _____

Street Address:	City:	State:	Zip Code:	Telephone #:

Email: (Non-DOC)	Work Location:	Work Phone #:

SPOUSE INFORMATION *(REQUIRED ON ALL CLAIMS)*

Spouse's Name (Print)	Birth Date:	Social Security #: (Last 4 digits) X X X - X X - _____	Is spouse covered by another Dental Plan? YES ☐ NO ☐

Name, Address, Telephone # of Spouse's Employer: **(MUST BE COMPLETED OR CLAIM WILL BE RETURNED)**	Name of Benefit Plan:

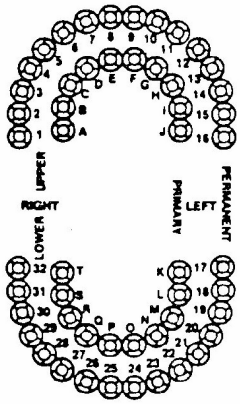
DENTIST INFORMATION (EXAMINER)

Dentist's Name: (Print)	License #:	Telephone #:	Taxpayer ID #:

Street Address:	City:	State:	Zip Code:

If Prosthesis, is this initial placement? ☐ Yes ☐ No	Date of Prior Placement:	Reason for Replacement:	Is this claim the result of: 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 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 that the services listed above ☐ have been ☐ will be performed.

_____ _____
Signed (Dentist) 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 for 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) 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. / understand / am financially responsible to the dentist for charges not covered by this authorization.*

_____ _____
Signed (Member) SIGNATURE ON FILE IS NOT ACCEPTABLE Date

FOR OFFICE USE ONLY

VERIFICATION SIGNATURE: _____ DATE ____/____/____ Check #: _____ Check Issued Date: ____/____/____