RETURN TO:

Administrative Services Only, Inc
PO Box 9005, Dept. 11
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238
WWW.ASONET.COM

NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION EMPLOYEE BENEFIT FUND DENTAL CLAIM

☐ **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 & POST TREATMENT X-RAYS FOR ROOT CANAL THERAPY AND NON-ROUTINE EXTRACTIONS

PATIENT INFORMATION *(REQUIRED ON CLAIMS FOR SPOUSES AND ELIGIBLE DEPENDENTS)*

Patient Name (if a dependent)	Birthdate	Relationship to Member Spouse ☐ Child ☐	Full Time College Student Yes ☐ No ☐	School

MEMBER INFORMATION

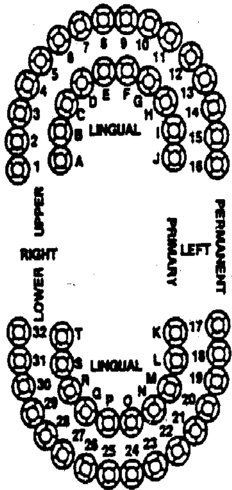
Member Name	Birthdate	Sex	Social Security#
Street Address	City	State	Zip / Telephone# ( )
Work Phone #		Home Phone #	

SPOUSE INFORMATION *(REQUIRED ON CLAIMS FOR SPOUSES AND ELIGIBLE DEPENDENTS)*

Spouse's Name	Spouse's Birthdate	Spouse's Social Sec. #	Is spouse covered by another Dental Benefits Plan? ☐ Yes ☐ No **If Yes, Specify Below.**
Name of Other Company/Organization Providing Benefits			Policy/Plan Number

DENTIST INFORMATION *(TO AVOID PROCESSING DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, ETC.)*

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 ☐



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 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: (If Patient is a legal adult, patient's signature is required under Authorization for Release of information)
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. **Authorization must be signed or payment will not be made.**

Signed (Employee) ______________________ Date ____________

ASSIGNMENT OF BENEFITS: *I hereby authorize payment directly to the above named dentist of the benefits otherwise payable to me. I understand I am financially responsible to the dentist for charges not covered by this authorization.*

Signed (Employee) ______________________ Date ____________