RETURN TO:

Administrative Services Only, Inc.
PO Box 9011
Department 146
Lynbrook, NY 11563
(877) 322-5385
(516) 394-9485
www.32bjdental.com

BUILDING SERVICE 32BJ HEALTH FUND

DENTAL CLAIM FORM

☐ **PRE-TREATMENT ESTIMATE**
(REQUIRED FOR INLAYS, CROWNS, 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	Relationship to Member	Full Time College Student	If over 19, student verification is required each semester and must be filed with the Fund.
		☐ Spouse ☐ Child	☐ Yes ☐ No	

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

Member Name	Birthdate	Sex	Social Security #

Street Address	City	State	Zip	Telephone #
				( )

Name of Other Company/Organization Providing Benefits	Policy/Plan Number	Start date:
		/ /

SPOUSE INFORMATION ***(REQUIRED ON ALL CLAIMS)***

Spouse's Name	Spouse's Birthdate	Spouse's Social Security Number	Is spouse covered by another Dental Benefits Plan? ☐ Yes ☐ No

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

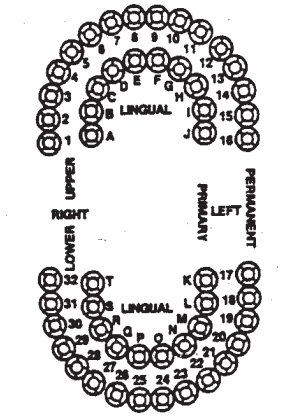
DENTIST INFORMATION *(TO AVOID DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, PRIMARY VOUCHERS, ETC.)*

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

Date Service Performed	Tooth # or Letter	Surface	ADA Code	Description of Service (including radiographs, prophylaxis, materials used, etc.)	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 the accuracy of the procedures and dates of completion as listed above.

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 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) **Date**

ASSIGNMENT OF BENEFITS ***(FOR PARTICIPATING PROVIDERS ONLY)*** **:** *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) **Date**

You may use universal or computer generated claim forms.
Please feel free to access our web site at www.32bjdental.com.