RETURN TO:
ADMINISTRATIVE SERVICES ONLY, INC.
PO Box 9005
Department 150
Lynbrook, NY 11563
(516) 396-5500

www.asonet.com
-Claim Forms
-Claim Inquiries
-PPO Dentists

CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL & FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND

DENTAL CLAIM FORM

☐ **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 *(REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)*

Patient Name	Birthdate	Relationship to Member Spouse ☐ Domestic Partner ☐ Child ☐	Full Time College Student Yes ☐ No ☐	School

MEMBER INFORMATION

Member Name	Birthdate	Sex	Social Security# XX X-XX-☐☐☐☐

Street Address	City	State	Zip	Telephone# ( )

Member Status ACTIVE ☐ RETIREE ☐	Court	Location	Work Telephone# ( )

SPOUSE INFORMATION *(REQUIRED ON CLAIMS FOR SPOUSES AND 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

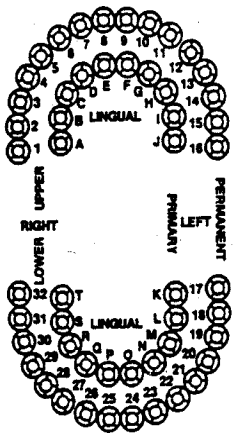
DENTIST INFORMATION *(TO AVOID PROCESSING DELAY BE SURE TO ENCLOSE X-RAYS, PERIO CHARTING, ETC.)*

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 ☐

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

FOR OFFICE USE	**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: Authorization must be signed or payment will not be made.
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 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 TO PARTICIPATING PROVIDER: ***Assignment of benefits will be made to Participating Dentists only.***
I hereby authorize payment directly to the above named Participating 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 _____