## PLEASE MAIL CLAIM FORMS TO:

## **SERVICE EMPLOYEES BENEFIT FUND**

P.O. Box 1240 • Syracuse, New York 13201

	1. PATIENT'S NAME			FIONSHIP TO SPOUSE CH		3. SE	X 4. PAT F MO	ENT BIRTH	DATE (	IF YE	S, YOU MI	PENDENT STU JST COMPLET OF FORM		9 OR OVER?	
	6. EMPLOYEE'S NAME 9. SOCIAL SECUP									11070	. IOL OIDE	. OI TONIVI	· · · · · · · · · · · · · · · · · · ·		
Ξ															
M	LAST 7. EMPLOYEE'S MAILING ADDR	FIF	ST		INITI	AL									
Р	7. Emileotees in tenta ribo.						10. EMPLC	YER							
L	CITY, STATE, ZIP	11. EMPLOYEE'S BIRTHDAY				′ МО:			DAY: YR:						
0			SPOUSE'S BIRTHDAY MO:					DAY		YR:					
Υ	SPOUSE	"YES" GIVE NAME	AND ADDRES	S OF YOUR S	POUSE'S EMF	PLOYER	•								
E	EMPLOYED? NO  13. IS PATIENT COVERED YES 14. NAME AND ADDRESS OF INSURANCE CARRIER											15. GRC	15. GROUP NUMBER		
E,	BY ANOTHER DENTAL PLAN?  NO														
	16. I CERTIFY THAT THE INFORMATION GIV PROCESS THIS CLAIM, BENEFITS ARE						I HEREBY AUT OTHERWISE P		NT DIRECTLY	TO THE E	BELOW NAMI	ED DENTIST OF T	HE GROUP INSU	JRANCE BENEFITS	
	EMPLOYEE EMPLOYEE														
1	18. DENTIST NAME			Di	ATE	25. IS TF	REATMENT F		YES II	YES, E	NTER BRI	EF DESCRIPT	Date _ Ion and dat	TES	
							OF OCCUPATIONAL ILLNESS OR INJURY?								
	19. MAILING ADDRESS	9. MAILING ADDRESS						26. IS TREATMENT RESULT OF AUTO ACCIDENT?							
			OTHER ACCIDENT?												
	CITY, STATE, ZIP	27. ARE ANY SERVICES COVERED BY													
	20. DENTIST SOC. SEC. OR T.I.	ANOTHER PLAN?  28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?				(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT									
	20. DENTIST SOC. SEC. OR 1.1.														
		ADIOGRAPHICS OR DDELS ENCLOSED	NO	YES	HOW	30. IS TI	REATMENT 8		+ +						
	IVA	DDEF9 ENCTOPED			MANY?	ORT	HODONTICS	?							
	IDENTIFY MISSING TEETH WITH "X" 31. EXAMINATION AND TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32 — USE CHARTING SYS												WN	FOR	
l	FACIAL TOOTH BURFACE DESCRIPTION # OR SURFACE										/ICE P	ROCEDURE			
D	8 7 8 9 10 11 (INCLUDING XRAYS, PROPHYL					.AXIS, MATERIALS USED, ETC.)				MO. DAY YEAR N		NUMBER			
E	(D)3 (O) D E F G (O) 14(B) (O) 2 (O) B (O) 10 15 (O)	<u> </u>								<u> </u>	<u> </u> 			ADMINISTA	
N	(D) (O) A J (O) 18 (O)										<u> </u>			NLY STR	
T	UPPER										<u> </u>			ADMINISTRATIVE USE ONLY	
ا د	RIGHT LINGUAL LEFT			,						j				m	
S T	[D]32 (D] <sup>T</sup> [K]D]17(D]														
ı	(C)31 (C)S L (C) 18 (C) (C)30 (C)B Q Q Q N (C) 19 (C)														
l		´								<u> </u>	<u> </u>			_	
1	₩ 24 23 24	-								<u> </u>					
	FACIAL 32. REMARKS FOR UNUSUAL									<u> </u>		······································			
	SERVICES ON REVERSE SIDE CHECK									1					
	CHECK ONLY ONE										<u> </u>	TOTAL			
	33. DENTIST'S TREATMENT PLAN (PRE-DETERMINATION OF BENEFITS).									FEE CHARGED					
	34. 🖵 DENTIST'S STATE		•			•				I AM A SPECIALIST IN: O ORAL SURGERY O ORTHODONTICS PERIODONTICS					
	I Hereby Certify That The Above Procedures Were Rendered On The Dates Indicated									ORTHODONICS    PERIODONICS     ENDODONICS    OTHER  REMARKS					
														- <b>Q</b> X	
	0.5								ı						
	35	Signed (Dentis	t)			· · · · · · · · · · · · · · · · · · ·	Date								
	36. □ IAM	37. TO BE COMP	LETED BY PAR												
		37. TO BE COMP	LETED BY PAR EEN PAID		IF "YES" A	MOUNT P	AID \$								

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P.O. Box /240 Syracuse, New York 13201