Reason for submission (Please ✓ one): Statement of Actual Completed Services

DENTAL CLAIM FORM

www.cseaebf.com 800-323-2732



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SUBSCRIBER INFORMATION Subscriber's Name													PATIENT INFORMATION Patient's Name											
Subscriber's Name												Patient's Name												
Male Female (Check one)											Male Female (Check one)													
Subscriber's EBF ID Number												Relationship to Subscriber (Check one)												
Street Address												Self Spouse Dependent Child Other												
CityStateZip																								
Oity_						0181	.6					GE INF	ORM.	ATIO	N									
Is other Dental coverage available? (Check one) Yes No											Subscriber's NameFirst Name, Middle, Last Name													
Name of Company											Date of Birth (mm/dd/yyyy)													
Other Dental Company Claim Address											Male Female (Check one)													
											Subscriber's ID Number													
												Plan/Group Number												
											Patient Relationship to Subscriber (Check one)													
CityStateZip											Self Spouse Dependent Child Other													
RECORD OF SER											VICES PROVIDED Description of Service											F		
Service	I				Tooth #/ Surf Letter/Quad				1CE				Description of Service										Fee	
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Remarks:																							Total	
Missing Teeth (Mark each m		1	2	3	4	5	6 7		8	9	10	11 12	13	14	15	16		P	В	С	D E	F	G H I	J
tooth with an	X.) [32	31	30	29	_	27 2	6 2	25	24	23	22 21	20	19				I	S	1	Q P	0	N M L	K
SUBSCRIBER AUTHORIZATION I hereby certify that the dated procedures have been completed.											ADDITIONAL INFORMATION Radiographs enclosed? (Yes/No)													
X												Is treatment for orthodontics? (Yes/No)												
Please issue payment directly to the dental entity below.												Date of insertion? (dd/mm/yyyy)												
X												Date of prior placement? (dd/mm/yyyy)												
BILLING DENTIST OR DENTAL ENTITY (NAME AND ADDRESS)											TREATING DENTIST Treating Dentist Sign Below													
										X														
NPI License # TIN or SSN									1															
			"									Date (mm/d	d/yyyy	/)				Line	no- "				
Phone Number												NPI							LIC	ense #				