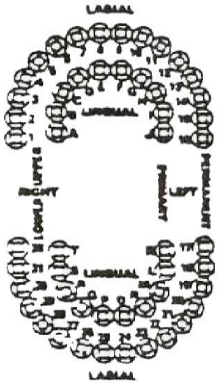
DENTAL CLAIM NOTICE
CAYUGA-ONONDAGA AREA SCHOOL EMPLOYEES' DENTAL CARE PLAN
ATTN: DENTAL ADMINISTRATOR
1879 W. GENESEE ST. RD.
AUBURN, NY 13021-9430
(315) 406-4461

PART 1 EMPLOYEE

Patient name		2. Relationship to Employee Self	Spouse	Child	Other	3. Sex M ☐ F ☐		4. Patient birth date Mo.	Day	Year	5. Full time student School		City		
6. Employee name First	Middle	Last				7. Employee Social Security No.					8. For Administrative Use only				
9. Employee Mailing Address						10. City, State, Zip									
10. Employer or Group Name						12. Employer or Group Address									
13. Are other family members employed? ☐ Yes ☐ No						14. Name and address of employer in item 13									
If Yes Indicate:	Name	Social Security Number													
15. Is patient covered by another dental plan? ☐ Yes ☐ No															
If Yes Indicate:	Dental Plan Name	Union local				Group No.					Name and address of claim administrator				
I have reviewed the following treatment plan. I authorize of any information relating to this claim.						I hereby authorize Payment directly to the below-named dentist of the dental plan benefits otherwise payable to me.									
Signed (Patient or Parent if minor)		Date				Signed (Employee)					Date				

PART 2 DENTIST

16. Dentist Name						24. Is treatment result of occupational illness or injury		NO	YES	If yes, enter brief description and dates					
17. Mailing Address						25. Is treatment result of auto accident?									
						26. Other accident?									
City, State, Zip						27. Are any services covered by another plan?									
18. Dentist Soc. Or T.I.N*	19. Dentist License No.		20. Dentist Phone No.			28. Is prosthesis or crown(s) is this initial placement?				(if no, reason for replacement)			29. Date of prior placement		
21. First visit date. Current series	22. Place of treatment	23. Radiograph or models enclosed	No	Yes	How many?	30. Is treatment for orthodontics?				If services already commenced. enter		Date appliance placed	Mos. Treatment remaining		
CHECK ONE ☐ Pre-determination estimate ☐ Statement of actual services	31. Examination and treatment plan - list in order from tooth no.1 through no.32 - (Use charting system shown)												For Administrative Use only		
	Tooth number or letter	Surface	DESCRIPTION OF SERVICE 9including x-rays, prophylasis, materials used, etc.)			Date service performed		Procedure number		Fee					
															
Indicate missing teeth with X															
32. Remarks for unusual services															
										TOTAL FEE	$				

PART 3

I hereby certify that services listed above have been performed on named patient on the dates indicated and that the fees shown are those currently charged to the majority of my patients.

SIGNED (DENTIST) _____ Date _____

* Must be furnished under Authority Law when Benefits Assigned