Reason for submission (Please ✓ one):

☐ Statement of Actual Completed Services

☐ Pretreatment Estimate/Predetermination

DENTAL CLAIM FORM

www.cseaebf.com 800-323-2732

Claim Address: PO Box 489 Latham NY 12110-0489

SUBSCRIBER INFORMATION

Subscriber's Name_____

Date of Birth (mm/dd/yyyy)_____

Subscriber's EBF ID Number_____

Street Address_____

City_____State_____Zip_____

Is other Dental coverage available? (Check one)

Name of Company_____

_____

_____

_____

_____

_____ _____ _____

Subscriber's Name_____

Date of Birth (mm/dd/yyyy)_____

Subscriber's ID Number_____

Plan/Group Number_____

Patient Relationship to Subscriber (Check one)

Self Spouse Dependent Child Other