

Dental Expense Claim

To Be Completed by Employee (You must review the important statements on page 2 and sign where indicated before completing this section of the form.)

1. Patient First Name _____ Middle _____ Last _____			2. Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Patient Date of Birth Mo. / Day / Year _____	6. For Office Use
7. If Full-Time Student (Age 19 or Over) School _____ City _____ State _____			8. ID Number _____		9. If Disabled (Age 19 or Over) <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Name of Group Dental Program _____	
11. Employee First Name _____ Middle _____ Last _____			12. Employee Date of Birth _____		13. Office Phone (Area Code) _____			
14. Employee Residence Mailing Address _____			15. City, State, Zip _____					
16. Are other Family Members Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ Social Security / ID Number _____			17. Date of Birth _____		18. Name and Address of Employer for Item 16 _____			
19. Is Patient Covered by Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete the following): Dental Plan Name _____ Group No. _____ Name and Address of Carrier _____								
20. I Authorize Release of any Information Relating to this Claim. _____ (Signature of Patient or Signature of Authorized Representative if Minor) _____ Date _____			21. I Certify that the Above Information is Correct. _____ Employee Signature _____ Date _____			22. I Authorize Payment Directly to the Below-Named Dentist. _____ Employee Signature _____ Date _____		
If Authorized Representative, Relationship to Minor _____								

To Be Completed by Dentist

23. Dentist Name _____		24. Mailing Address _____ City _____ State _____ Zip _____	
25. Dentist Phone Number _____	26. Dentist License Number _____	27. Dentist SSN or T.I.N. _____	28. Provider Specialty Code _____
29. NPI (Treating Dentist) _____	30. NPI (Billing Entity, if different) _____		31. First Visit Date Current Series _____
32. Place of Treatment <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other _____		33. Radiographs or Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No How Many? _____	
34. Is Treatment Result of Occupational Illness or Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates) _____		35. Is Treatment Result of Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates) _____	
36. Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates) _____		37. Are any Services Covered by Another Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates) _____	
38. If Prosthesis, is this Initial Placement? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, Reason for Replacement) _____			39. Date of Prior Replacement _____
40. Is Treatment for Orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Services Already Commenced, Enter Date Appliance Placed _____		Months of Treatment Remaining _____

Dentist's - Pretreatment Estimate Statement of Actual Services (Be sure to sign below)*

	41. Examination and Treatment Plan - List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)						
	Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day /Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Hereby Certify That The Services Listed Above <input type="checkbox"/> Will Be <input type="checkbox"/> Have Been Performed.			Total Fee Actually Charged	
*Signature of Dentist _____		Date Signed _____		
43. Address where treatment was performed Street _____ City _____ State _____ Zip _____				

If you are covered under a self-insured plan or insured under a policy issued in any state other than those listed below, or if you reside in any state other than those listed below, then the following warning may apply to you:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.#

If you are insured under a policy issued in one of the following states, or if you reside in one of the following states, one of the following state warnings may apply to you:

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to \$5,000 plus the value of the claim.

California: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas, Oregon and Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee Signature _____ Date _____

Please Review Before Submitting Claim

Information for Employee

1. Complete your section of the claim form (items 1 through 21) in full to assure positive identification and prompt payment. Please print or type. **Note:** Item 8 (ID Number) **must be completed** for the claim to be processed.
2. **Patient Consent.** By signing item 20, the **patient** (or parent or other authorized representative) consents to the use and disclosure of information relating to the services provided by the dentist or health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for dental benefits to a provider or administrator of dental benefit plans. This consent will be valid for as long as the patient is entitled to coverage under a dental plan. You are entitled to a copy of this consent. This consent may be revoked in writing delivered to your dentist or health care professional, but such revocation will not affect any action taken in reliance on this consent prior to revocation. Upon receipt of revocation or refusal to sign a consent, your dentist or health care professional may decline to provide or continue treatment. If this consent is signed by the authorized representative of the patient, the relationship of the authorized representative must be provided in item 20.
3. You must sign the claim form in item 21.
4. You can arrange for MetLife to make payment directly to the dentist by completing item 22. If you wish benefits to be paid directly to yourself, do not complete item 22. In either case, a statement of benefits paid will be sent to you.
5. If total charges for the planned course of treatment are expected to be \$300 or more, the form should be completed and submitted to MetLife **prior to the commencement of the course of treatment** for a pretreatment estimate of benefits. MetLife will notify you of your benefits payable. (If you wish, a pretreatment estimate may be requested for anticipated dental expenses of less than \$300.)
6. If total charges for the planned course of treatment will be less than \$300, the claim form should be completed when treatment is completed and mailed to the address shown below. **Dental Coverage is subject to specific limitations and exclusions. Please refer to your booklet for a description of covered services, schedule of benefits payable, limitations and exclusions.**

Information for Attending Dentist

1. Benefits are payable in accordance with four Classes of Services. It is therefore important that a separate fee is indicated for each item of service performed.
2. If total charges for a course of treatment are expected to be \$300 or more, check the box noted "Pretreatment Estimate" and complete items 23 through 42. The completed claim form should be sent to the address shown below **prior to the commencement of the course of treatment**. MetLife will review the claim (and any supplementary information required) and notify your patient of the benefits payable.
3. If the address where treatment was performed is different from the mailing address in item 24, complete item 43.
4. Generally, we do **not** request x-rays where standard filling materials are used. Pre-operative x-rays are requested **only** in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally we may request x-rays that relate to other dental services.
In an effort to reduce your costs and inconvenience, we request your cooperation in submitting x-rays **only** in the above-mentioned circumstances or when specifically requested. This will also enable us to expedite the processing of a pretreatment estimate.
5. If authorized by the employee, benefit payments will be made directly to you.

Mail Completed form to:

MetLife Dental Claims

P.O. Box 14588

Lexington, KY 40512

Dentists: 1-877-638-3379