Group Dental

Dental expense claim

MetLife

Metropolitan Life Insurance Company

SECTION 1: To be completed by Employee

Patient information

1. First name	Middle name	Last name

2. Relationship to employee	3. Sex	4. Married?	5. Patient DOB	6. For office use
☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	☐ Yes ☐ No		

If full-time student *(age 19 or over)*

7. School name and address	City	State	ZIP

8. ID number	9. If disabled *(age 19 or over)* ☐ Yes ☐ No	10. Name of group Dental program

Employee information

11. First name	Middle name	Last name

12. Residence mailing address	City	State	ZIP

13. Employee DOB	14. Office phone *(area code)*	15. Are other family members employed? ☐ Yes ☐ No

16. Name of Employed family member	Social Security/ID number	Date of birth

17. Name of employer for Item 16

18. Employer address	City	State	ZIP

19. Is patient covered by another Dental Plan? ☐ Yes *(If yes, complete the following:)* ☐ No	Dental plan name	Group number

Name of Carrier

Address of Carrier	City	State	ZIP

20. I authorize release of any information relating to this claim.

Sign Here	Signature of patient or authorized representative if minor	If authorized representative, relationship to minor	Date

21. I certify that the above information is correct.

Sign Here	Employee signature	Date

22. I authorize payment directly to the below-named dentist.

Sign Here	Employee signature	Date

SECTION 2: To be completed by Dentist

23. Dentist – First name	Middle name	Last name

24. Mailing address	City	State	ZIP

25. Phone number	26. 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
☐ Office ☐ Hospital ☐ ECF ☐ Other_____

33. Radiographs or Models enclosed?
☐ Yes ☐ No How many? _____

34. Is treatment result of occupational illness or injury?
☐ Yes ☐ No *(If yes, enter brief description and dates)*

35. Is treatment result of auto accident?
☐ Yes ☐ No *(If yes, enter brief description and dates)*

36. Other accident?
☐ Yes ☐ No *(If yes, enter brief description and dates)*

37. Are any services covered by another plan?
☐ Yes ☐ No *(If yes, enter brief description and dates)*

38. If prosthesis, is this initial placement? *(If no, reason for replacement)*
☐ Yes ☐ No

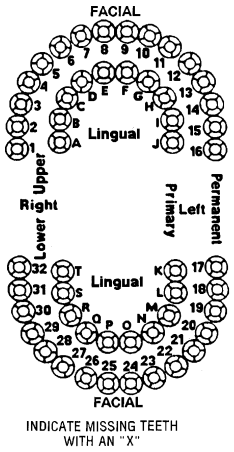
39. Date of prior replacement

40. Is treatment for orthodontics? ☐ Yes ☐ No
If services already commenced, 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 *(mm/dd/yyyy)*	ADA Procedure Number	Fee	For Carrier Use Only

Total fee	
Actually charged	

42. I hereby certify that the services listed above ☐ will be ☐ have been performed.

Sign Here *Signature of Dentist | Date signed

43. Address where treatment was performed - Street	City	State	ZIP

SECTION 3: Instructions *(Please review these instructions before submitting claim.)*

1. FRAUD WARNINGS

Before completing this form, please read the following fraud warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form: 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.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana, and Oklahoma: WARNING: 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.

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

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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 is a crime.

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

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

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

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: 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.

Pennsylvania and all other states: 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 is a crime and subjects such person to criminal and civil penalties.

2. CLAIM SUBMISSION INFORMATION

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 operations, 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 or faxed to the address or fax number 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.

SECTION 4: How to submit this form

- If you are submitting a claim, please complete and detach the first and second pages only and mail them to the below address or fax them to the number indicated.
- If you are requesting that the form be translated into Spanish or Chinese, please visit our website, www.metlife.com, and download the applicable claim form from our Dental Insurance Center.
- Or you may mail the entire six (6) pages of this form to the address shown on page 6.

Mail:
MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Fax:
1-859-389-6505

Dentist's telephone:
1-877-638-3379

CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
NOTICE TO INSUREDS

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept of Insurance at 1-800-927-4357.
To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Please indicate to whom and where the translated document is to be sent.

D **Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un interprets. Se le pueden leer documentos y enviar algunos en espafiol. Para recibir ayuda, llamenos al numero que aparece en su tarjeta de identificaci6n, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.
Para recibir una copia del documento adjunto de MetLife traducido al espafiol, marque la casilla correspondiente a esta oraci6n, y envie par correo el documento junta con este formulario a:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Par favor, indique a quien ya d6nde debe enviarse el documento traducido.
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Libreng serbisyo sa pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

Ojch v1,1thong djch mien phi. Quy vi c6 the tim mot thong dich vien va nha doc cac tai lieu na cho quy vi b ng ti4ng Viet. Oe dU'Q'C giup do, goi cho chung toi t i s6 neu tren the ID cua quy vi, n u c6, ho c 1-800-942-085.4 Oe dU'Q'C giup do them goi cho Ban Bao Hiem CA t i s6 1-800-927-4357.

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