



Dental Expense Claim Form

(Please Read Instructions on Reverse Side before Completing this Form)

TO BE COMPLETED BY EMPLOYEE

TO BE COMPLETED BY DENTIST

1. Patient First Name Middle Last			2. Relationship to Employee Self Spouse Child Other				3. Sex M F		4. Married Yes No		5. Patient Date of Birth Mo Day Year			6. Report Number
7. If Full Time Student (Age 19 or Over) School City State				8. EMPLOYEE SOC. SEC. NO.				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 Soc. Sec. No.			17. Date of Birth		18. Name and Address of Employer for Item 16							
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19. Is Patient Covered by Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			Dental Plan Name			Group No.		Name and Address of Carrier				
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20. I Authorize Release of any Information Relating to this Claim.			21. I Certify that the Above Information is Correct.				22. I Authorize Payment Directly to the Below Named Dentist.				
Signed (Patient, or Parent if Minor) _____ Date _____			Employee Signature _____ Date _____				Employee Signature _____ Date _____				

23. Dentist Name				31. Is Treatment Result of Occupational Illness or Injury?		No		Yes		If Yes, Enter Brief Description and Dates									
24. Mailing Address				32. Is Treatment Result of Auto Accident?		No		Yes											
City, State, Zip				33. Other Accident?		No		Yes											
25. Dentist Soc. Sec. No. or T.I.N.				26. Dentist License No.		27. Dentist Phone No.		35. If Prosthesis, is this Initial Placement?		(If No, Reason For Replacement)		36. Date of Prior Placement							
28. First Visit Date Current Series		29. Place of Treatment Office Hosp ECF Other		30. Radiographs or Models Enclosed?		No		Yes		How Many?		37. Is Treatment for Orthodontics?		If Services Already Commenced, Enter		Date Appliance Placed		Mos. Treatment Remaining	

Dentist's <input type="checkbox"/> Pre-Treatment Estimate <input type="checkbox"/> Statement of Actual Services *(Be Sure To Sign Below)		38. Examination and Treatment Plan-List in Order From Tooth No. 1 Through Tooth No. 32 Use Charting System Shown										For Carrier Use Only				
Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line No.	Date Service Performed			ADA Procedure Number	Fee									
			Mo.	Day	Yr.											
INDICATE MISSING TEETH WITH AN "X"																

I Hereby Certify That The Services Listed Above <input type="checkbox"/> Will Be <input type="checkbox"/> Have Been Performed.										Total Fee Actually Charged	
_____ Date _____											

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 and subjects such person to criminal and civil penalties.

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 that item 8 (employee social security number) **must be completed** for the claim to be processed.
2. The **patient** (or parent if patient is a minor) must sign item 20.
3. You must sign the claim form in item 21.
4. You can arrange for Metropolitan 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 \$200 or more, the form should be completed and submitted to Metropolitan **prior to the commencement of the course of treatment** for a pretreatment estimate of benefits. Metropolitan will notify you of your benefits payable.
(If you wish, a pretreatment estimate may be requested for anticipated dental expenses of less than \$200.)
6. If total charges for the planned course of treatment will be less than \$200, 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 completed course of treatment are less than \$200, check the box noted "Statement of Actual Services" and complete items 23 through 38. The claim form should then be sent to the address shown below.
3. If total charges for a course of treatment are expected to be \$200 or more check the box noted "Pre-Treatment Estimate" and complete items 23 through 38. The completed claim form should be sent to Metropolitan **prior to the commencement of the course of treatment**. Metropolitan will review the claim (and any supplementary information required) and notify your patient of the benefits payable.
A pretreatment estimate of benefits is not intended to preclude a course of treatment agreed upon by you and your patient. The intent is to avoid any misunderstanding concerning the benefits payable under the dental plan. A pretreatment estimate is not necessary for oral examinations, cleanings, fluoride applications, dental x-rays, or emergency treatment.
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 payment will be made directly to you.

**Mail completed form to: MetLife Dental Claims Unit
P. O. Box 14093
Lexington, KY 40512-4093**

**Claim Inquiries: 1-800-ASK-4MET
1-800-275-4638**