

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

TO BE COMPLETED BY EMPLOYEE

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								
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						
20. I Authorize Release of any Information Relating to this Claim Signed (Patient, or Parent if Minor) Date						21. I Authorize Payment Directly to the Below Named Dentist. Employee Signature Date							

22. I declare that the above information is correct.
If you are covered under a self-insured plan or 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 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.

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 Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
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.
Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement may have violated state law.
New York: 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.

TO BE COMPLETED BY DENTIST

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?				
City, State, Zip		33. Other Accident?				
25. Dentist Soc. Sec. No. or T.I.N.		26. Dentist License No.		27. Dentist Phone No.		34. Are any Services Covered by Another Plan?
28. First Visit Date Current Series		29. Place of Treatment Office Hosp ECF Other		30. Radiographs or Models Enclosed? No Yes How Many?		
35. If Prosthesis, is this Initial Placement?		36. Date of Prior Placement		(If No, Reason For Replacement)		
37. Is Treatment for Orthodontics?		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 Thro ugh 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 Mo. Day Yr.			ADA Procedure Number	Fee	
I Herby Certify That The Services Listed Above <input type="checkbox"/> Will Be <input type="checkbox"/> Have Been Performed.							Total Fee Actually Charged	
*Signed (Dentist) _____ Date _____								

Please Review Before Submitting Claim

Information for Employee

1. Complete your section of the claim form (items 1 through 22) 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 22.
4. You can arrange for Metropolitan to make payment directly to the dentist by completing item 21. If you wish benefits to be paid directly to yourself, do not complete item 21. 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
P. O. Box 14093
Lexington, KY 40512-4093**

Claim Inquiries: 1-800-942-0854