

## Dental Expense Claim

**To Be Completed by Employee**

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 <b>Federal Deposit Insurance Corporation</b>
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. <b>148795</b> 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)\*

<p style="font-size: small;">INDICATE MISSING TEETH WITH AN "X"</p>	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	
*Signature of Dentist _____		Date Signed _____		Actually Charged	
43. Address where treatment was performed					
Street _____		City _____		State _____	Zip _____

## FRAUD WARNINGS

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

**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.

**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.

**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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 R.S.A. 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each 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 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.

## CLAIM SUBMISSION INFORMATION

### Please Review These Instructions 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.

#### Detach and mail the completed Dental Expense Claim Form to:

**MetLife Dental Claims**  
**P.O. Box 14588**  
**Lexington, KY 40512**

**Dentists: 1-877-638-3379**

If you are submitting a claim, please complete and detach the first page only and mail it to the above address. If you are requesting the form be translated into Spanish or Chinese, please visit our website, [www.metlife.com](http://www.metlife.com), and download the applicable claim form from our Dental Insurance Center. Or you may mail the entire four (4) pages of this form to the address on page 4. 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.