

**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 2. Relationship to Employee 4. Married? 5. Patient Date of Birth Middle 3. Sex 6. For Office Use Mo./Day/Year ☐ Self ☐ Spouse ☐ Male Yes ☐ Child ☐ Other ☐ Female ☐ No 8. EMPLOYEE Social Security/ID Number 9. If Disabled 7. If Full-Time Student (Age 19 or Over) 10. Name of Group Dental Program (Age 19 or Over) School State Yes No 13. Office Phone (Area Code) 11. Employee First Name Middle 12. Employee Date of Birth Last 14. Employee Residence Mailing Address 15. City, State, Zip 17. Date of Birth 18. Name and Address of Employer for Item 16 16. Are other Family Members Employed? Yes No Social Security/ID Number 19. Is Patient Covered by Another Dental Plan? Yes No (If Yes, complete the following:) Name and Address of Carrier Dental Plan Name Group No. 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. (Signature of Patient or Signature of Authorized Date Representative if Minor) Date Date Employee Signature Employee Signature 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 33. Radiographs or Models Enclosed? ☐ Office ☐ Hospital ☐ ECF ☐ Other ☐ Yes ☐ No How Many? 35. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates) (If Yes, Enter Brief Description and Dates) 37. Are any Services Covered by Another Plan? 36. Other Accident? Yes No (If Yes, Enter Brief Description and Dates) Yes No (If Yes, Enter Brief Description and Dates) 39. Date of Prior Replacement 40. Is Treatment for Orthodontics? If Services Already Commenced, Enter Date Appliance Placed Months of Treatment Remaining Yes No **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) Date Service ADA Tooth # Description of Services For Carrier Surface Performed Procedure Fee or Letter (Including X-Rays, Prophylaxis, Materials Used, Etc.) Use Only Mo./Day/Year Number INDICATE MISSING TEETH WITH AN "X" 42. I Hereby Certify That The Services Listed Above Will Be Have Been Performed. Total Fee \* Signature of Dentist Date Actually Charged

City

State

Zip \_

Street

43. Address where treatment was performed

If you are covered under a self-insured plan or insured under a policy issued in any state other than those listed below, <u>or</u> 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.

<u>California:</u> 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.

<u>Florida:</u> 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.

<u>Massachusetts:</u> 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.

<u>Kansas, Oregon and Vermont:</u> 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.

<u>Puerto Rico:</u> 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.

<u>Virginia and Washington:</u> 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

- Incomplete 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 (Employee Social Security/ 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 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 981282 El Paso, TX 79998-1282

Employees: 1-800-942-0854 Dentists: 1-877-638-3379