

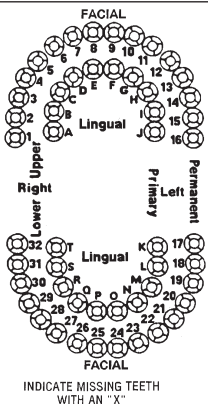
Dental Expense Claim

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 N/A City N/A State N/A	8. MetLife ID Number	9. If Disabled (Age 19 or Over) <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Name of Group Dental Program Federal Dental Insurance 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? Name <input type="checkbox"/> Yes <input type="checkbox"/> No ID Number	17. Date of Birth	18. Name and Address of Employer for Item 16			
19a. Is Patient Covered by a Medical Plan that Provides Dental Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete the following): Plan Name _____ Group No./Plan No. _____ Name and Address of Carrier, and Carrier-Issued Identification No. _____					
19b. Is Patient Covered by Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete the following): Plan Name _____ Group No./Plan No. _____ 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 _____ If Authorized Representative, Relationship to Minor _____	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 _____			

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 Medical or Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description, Dates, Plan Name and Plan Number)			
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 — <input type="checkbox"/> Pretreatment Estimate <input type="checkbox"/> 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 Mo./Day/Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Herby Certify That The Services Listed Above <input type="checkbox"/> Will Be <input type="checkbox"/> Have Been Performed. * Signature of Dentist _____ Date _____ Total Fee Actually Charged _____		
43. Address where treatment was performed Street _____ City _____ State _____ Zip _____		

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: Item 8 (MetLife 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.
7. If you answered "Yes" to question 19a, please enter all requested information for that section including: Plan Name, Group No./Plan No., Name and Address of Carrier, and Carrier-Issued Identification Number; for example, R12345678. This provided information will assist in the expediting of your claim(s).

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.
6. If the patient answered "Yes" to question 19a, please ensure that the patient enters all requested information for that section including: Plan Name, Group No./Plan No., Name and Address of Carrier, and Carrier-Issued Identification Number; for example, R12345678. This provided information will assist in the expediting of the patient's claim(s).

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

Fax Completed Claim forms to:
859-389-6505

Employees: 1-888-865-6854
On-line claim information, please visit:
www.federaldental.metlife.com

Dentists: 1-877-638-3379