Group Dental

MetLife

Dental expense claim

Metropolitan Life Insurance Company

SECTION 1: To be completed by Member

Patient information

1. First name | Middle name | Last name

2. Relationship to member ☐ Self ☐ Spouse ☐ Child ☐ Other | 3. Sex ☐ Male ☐ Female | 4. Married? ☐ Yes ☐ No | 5. Patient DOB | 6. For office use

7. If full-time student *(age 19 or over)*
School | City | State | ZIP

8. ID number | 9. If disabled *(age 19 or over)* ☐ Yes ☐ No | 10. Name of group dental program

Member information

11. First name | Middle name | Last name

12. Residence mailing address | City | State | ZIP

13. Member DOB | 14. Office phone *(area code)* | 15. Are other family members employed? ☐ Yes ☐ No

16. Name of Employed family member | Social Security/ID number | Date of birth

17. Name of employer for Item 16

18. Employer address | City | State | ZIP

19. Is patient covered by another Dental Plan? ☐ Yes *(If yes, complete the following:)* ☐ No | Dental plan name | Group number

Name of Carrier

Address of Carrier | City | State | ZIP

20. I authorize release of any information relating to this claim.

Sign Here Signature of Patient or Authorized representative if minor | If authorized representative, relationship to minor | Date

21. I certify that the above information is correct.

Sign Here Signature of Member | Date

22. I authorize payment directly to the below-named dentist.

Sign Here Signature of Member | Date

SECTION 2: To be completed by Dentist

23. Dentist – First name	Middle name	Last name

24. Mailing address	City	State	ZIP

25. Phone number	26. 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
☐ Office ☐ Hospital ☐ ECF ☐ Other _____

33. Radiographs or Models enclosed?
☐ Yes ☐ No How many? _____

34. Is treatment result of occupational illness or injury?
☐ Yes ☐ No *(If yes, enter brief description and dates)*

35. Is treatment result of auto accident?
☐ Yes ☐ No *(If yes, enter brief description and dates)*

36. Other accident?
☐ Yes ☐ No *(If yes, enter brief description and dates)*

37. Are any services covered by another plan?
☐ Yes ☐ No *(If yes, enter brief description and dates)*

38. If prosthesis, is this initial placement? *(If no, reason for replacement)*
☐ Yes ☐ No

39. Date of prior replacement

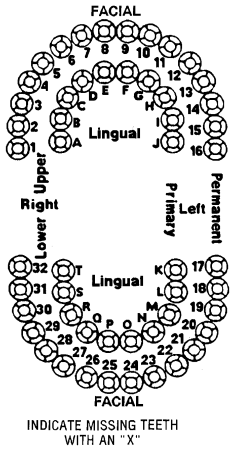
40. Is treatment for orthodontics? ☐ Yes ☐ No

If services already commenced, date appliance placed

Months of treatment remaining

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)*



Tooth # or Letter	Surface	Description of Services *(Including X-Rays, Prophylaxis, Materials Used, Etc.)*	Date Service Performed *(mm/dd/yyyy)*	ADA Procedure Number	Fee	For Carrier Use Only

Total fee

Actually charged

42. I hereby certify that the services listed above ☐ will be ☐ have been performed.

Sign Here *Signature of Dentist

Date signed

43. Address where treatment was performed - Street

City

State

ZIP