

Dental expense claim

Metropolitan Life Insurance Company

SECTION 1: To be compl	eted by Mem	ber					
Patient information 1. First name	Middle name		Last name				
2. Relationship to member 3. Sex ☐ Self ☐ Spouse ☐ Child ☐ Other ☐ Male			1. Married? ☐ Yes ☐ No			6. For office use	
7. If full-time student (age 19 or o School	ver)	City			State	ZIP	
8. ID number	9. If disabled (a	ige 19 or over No) 10. Name o	f group de	ntal pro	l gram	
Member information			-1				
11. First name	Middle name		Last name				
12. Residence mailing address		City			State	ZIP	
13. Member DOB 14. Office	e phone (area co	· I —	other family m ∕es	nembers er	mployed	j? 	
16. Name of Employed family mer		Social Secu	rity/ID num	nber	per Date of birth		
17. Name of employer for Item 16							
18. Employer address		City			State	ZIP	
19. Is patient covered by Peranother Dental Plan?		n name		Group number			
Name of Carrier							
Address of Carrier		City			State	ZIP	
20. I authorize release of any Sign Signature of Patient of Here		_	If autho	orized repr nship to mi	esentati nor	ive, Date	
21. I certify that the above in Sign Here		orrect.				Date	
22. I authorize payment direct Sign Here	=	w-named den	tist.			Date	

SECTION 2: To be completed by Dentist											
23. Dentist - First n	ame	ne Middle name				Last name					
24. Mailing address			City				State ZIP				
25. Phone number 26. License number		2	27. Dentist SSN or T.I.N.			28. Provider specialty code					
29. NPI (treating dentist) 30. NPI (billing entity, if different) 31. First visit dat							late curre	ent series			
32. Place of treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other					33. Radiographs or Models enclosed? ———————————————————————————————————						
34. Is treatment result of occupational illness or injury? 35. Is treatment result of auto accident? Yes \sum No (If yes, enter brief description and dates) Yes \sum 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)								nd dates)			
38. If prosthesis, is this initial placement? (If no, reason for replacement) 39. Date of pri							or replacement				
40. Is treatment for Orthodontics? No If services already commenced, date appliance placed Months of treatment remaining											
41. Examination ar	Dentist's - ☐ Pretreatment estimate ☐ Statement of actual services (<i>Be sure to sign below</i>)* 41. Examination and Treatment Plan – List in order from tooth #1 through tooth #32 (<i>Use charting system</i>										
Shown) FACIAL FACIAL	Tooth # or Letter	urface (Inch	luding	ription of g X-Rays erials Us	s, Prophy	ylaxis,	Date Sel Perforn (mm/dd/	ned	ADA Procedure Number	Fee	For Carrier Use Only
Right Primary											
22 7 6 5 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Ď										
INDICATE MISSING TEETH WITH AN "X"	:										
									Total fee		
Actually charged											
42. I hereby certify that the services listed above will be have been performed. *Sign *Signature of Dentist Here								Date signed			
43. Address where treatment was performed - Street City State							ZIP				



Fraud Warnings

State Specific Fraud Warnings - Group Product Claim Forms

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.

Alabama, 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.

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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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: 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.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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.

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 and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 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.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

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.

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.

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.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

SECTION 3: Instructions (*Please review these instructions before submitting claim.*) **CLAIM SUBMISSION INFORMATION**

Information for member

- 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 operations, 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 or faxed to the address or fax number 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 member, benefit payments will be made directly to you.

SECTION 4: How to submit this form

- If you are submitting a claim, please complete and detach the first and second pages only and mail them to the below address or fax them to the number indicated.
- If you are requesting that the form be translated into Spanish or Chinese, please visit our website, www.metlife.com, and download the applicable claim form from our Dental Insurance Center.
- Or you may mail the entire six (6) pages of this form to the address shown on page 6.

Mail: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 **Fax:** 1-859-389-6505

Dentist's telephone: 1-877-638-3379

JY0333-A-2 (08/21) Fs/f

CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM NOTICE TO INSUREDS

No Cost Language Services. 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. For more help call the CA Dept. of Insurance at 1-800-927-4357.

To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:

Metropolitan Life Insurance Company

Lexington, KY 40512

800-927-4357 հեռախոսահամարով։

請指明經翻譯文件收件人的姓名及地址。

PO Box 14587

Lexington, KY 40512

Please indicate to whom and where the translated document is to be sent. Servicio de Idiomas Sin Costo. Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir avuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir avuda adicional llame al Departamento de Seguros de California al 1-800-927-4357. Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a: Metropolitan Life Insurance Company PO Box 14587 Lexington, KY 40512 Por favor, indique a quién y a dónde debe enviarse el documento traducido. **NOMBRE** DIRECCIÓN **免費語言服務**。您可獲得免費口譯服務。您可要求翻譯員向你口譯文件,或可要求向你發回文件的中文譯本。如需協助, 請致電您的ID卡上所示號碼(如有),或 1-800-942-0854。如需更多協助,請致電加州保險部熱線1-800-927-4357。 為收取隨附MetLife文件的中文譯本,請勾選此陳述前的方框,並將文件連同此表一併郵寄至: Metropolitan Life Insurance Company PO Box 14587

姓名 地址 **Անվձար թարգմանչական ծառայություններ։** Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը։ Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854։ Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-

សេវាបកប្រែដោយឥតគិតថ្ងៃ ។ អ្នកអាចទទល់បានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្លាប់ជាភាសាខែរ ។ សម្រាប់ជំនយ សមទរស័ពមកយើង តាមលេខដែល មានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមឡេត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) สาษเมอ 1-800-927-4357 ฯ

Kev pab txhais lus tsis kom them nqi. Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus Ivsaws-las ntawm 1-800-927-4357.

無料の通訳サービス。通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちのIDカードに記載さ れている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせくだ

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357로 캘리포니아 보험국에 연락하여 주십시오.

Бесплатные услуги устного перевода. Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

Libreng serbisyo sa pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

Dịch vụ thông dịch miễn phí. Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

لا تتوفر خدمات ترجمة بتكلفة. يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 485-942-800-1. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 7437-800-1. سرویس های ترجمه رایگان. شما می تو انید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای را هنمایی،از طریق شماره در ج شده در کارت شناسایی خود (در صورت وجود) يا شماره 854-942-980-1 با ما تماس بگيريد. براي راهنمايي بيشتر با بخش بيمه كاليفرنيا 4357-927-900-1 تماس بگيريد. **بلا معاوضه مترجم دی خدمات مل سکدی اے۔**تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اوے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گر ہوتو، دے وچ نمبر یا 484-942-98-10 په کال کرو۔ آگے مزید مدد واسطے اے نمبر 4357-927-800-1 په سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔