Group Dental - Metropolitan Life Insurance Company

MetLife

Dental expense claim

This Group Dental program is provided by your employer on a non-insured basis, and MetLife is providing administrative services only.

SECTION 1: To be completed by Employee

Patient information

1. First name | Middle name | Last name

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

If full-time student *(age 19 or over)*

7. School name and address | City | State | ZIP

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

Employee information

11. First name | Middle name | Last name

12. Residence mailing address | City | State | ZIP

13. Employee 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 15

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 Employee signature | Date

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

Sign Here Employee signature | Date

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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

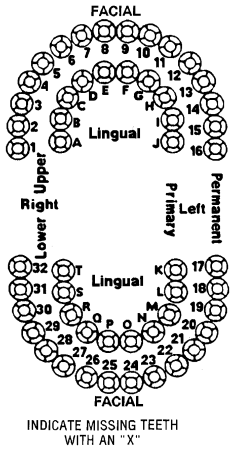
40. Is treatment for orthodontics? ☐ Yes ☐ No

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	City	State	ZIP

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

CLAIM SUBMISSION INFORMATION

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 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 employee, 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 four (4) pages of this form to the address shown on page 4.

Mail:	**Fax:**	**Dentist's telephone:**
MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282	1-859-389-6505	1-877-638-3379

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
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 ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda 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
Lexington, KY 40512
請指明經翻譯文件收件人的姓名及地址。
姓名_____
地址_____

Անվճար 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 1-800-927-4357 հեռախոսահամարով:

សេវាបកប្រែដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

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 lv-saws-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さい。

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 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 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.

سرویس های ترجمه رایگان. شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی،از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) یا شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

بلا معاوضہ 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 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔