

## Dental Expense Claim

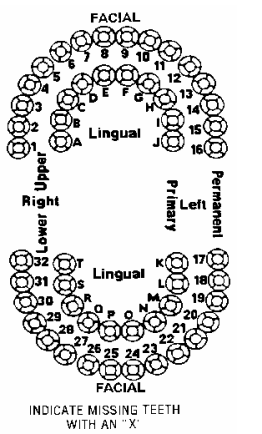
### To Be Completed by Employee

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 _____ City _____ State _____			8. ID Number _____		9. If Disabled (Age 19 or Over) <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Name of Group Dental 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ Social Security / ID Number _____			17. Date of Birth _____		18. Name and Address of Employer for Item 16 _____		
19. Is Patient Covered by Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, complete the following:) Dental Plan Name _____ Group 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 _____			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 _____	
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 <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 Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Enter Brief Description and Dates) _____		
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 -  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 Mo./Day/Year	ADA Procedure Number	Fee	For Carrier Use Only

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

## CLAIM SUBMISSION INFORMATION

### Please Review These Instructions 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 (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 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 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.

**Detach and mail the completed Dental Expense Claim Form to:**

**MetLife Dental Claims  
P.O. Box 981282  
El Paso, TX 79998-1282**

**Dentists: 1-877-638-3379**

**Tips for Completing the Dental Expense Claim Form** When you start filling out this form, you will find that some of it is easy, but other parts will leave you wondering. So I called MetLife Customer Service at 877-963-8932 to get some answers. Here's what I found.

(Note that this applies to the latest form, issued 3/09. Note also that you can complete most of this form online.)

- When Box 8 asks for "ID Number" you should enter your social security number.
- When Box 10 asks for the "Name of Group Dental Program," you should enter "Port Authority of NY and NJ – 302078"
- Include your PA employee number with your name in Box 11.
- When Box 16 asks "Are other Family Members Employed," just enter "N/A" unless you have other family members eligible for MetLife coverage.
- If you entered "N/A" in box 16, enter "N/A" in boxes 17 and 18 also --- Hope this helps! --- Tom Kearney, Ret. 2/89