Group Dental

MetLife

Dental expense claim

Metropolitan Life Insurance Company

SECTION 1: To be completed by Employee

Patient information

1. First name	Middle name	Last name

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

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)*	10. Name of group Dental program
5358629	☐ Yes ☐ No	Red Hook School Support Staff

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 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 — Employee signature	Date

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

Sign Here — Employee signature	Date

JY0333-1 (08/21)

Fs/f

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)*

FACIAL
Upper Right — Lower — Lingual — Primary — Permanent — Left
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
A B C D E F G H I J
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
T S R Q P O N M L K
FACIAL
INDICATE MISSING TEETH WITH AN "X"

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