FITZHARRIS & COMPANY

MetLife
Metropolitan Life Insurance Company

Dental Expense Claim

Group # 5358615

To Be Completed by Employee

1. Patient First Name / Middle / Last	2. Relationship to Employee	3. Sex	4. Married?	5. Patient Date of Birth Mo. / Day / Year	6. For Office Use
	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	☐ Yes ☐ No		

7. If Full-Time Student (Age 19 or Over) School / City / State	8. ID Number	9. If Disabled (Age 19 or Over) ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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.	21. I Certify that the Above Information is Correct.	22. I Authorize Payment Directly to the Below-Named Dentist.
_____ _____ (Signature of Patient or Signature of Authorized Representative if Minor) / Date _____ If Authorized Representative, Relationship to Minor	_____ _____ Employee Signature / Date	_____ _____ Employee Signature / Date

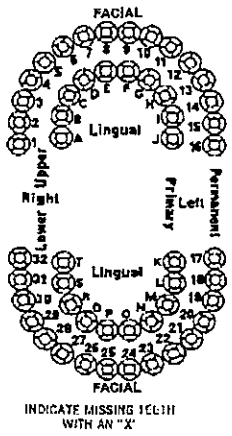
To Be Completed by Dentist

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 ☐ 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? ☐ Yes ☐ No (If No, Reason for Replacement)	39. Date of Prior Replacement
40. Is Treatment for Orthodontics? ☐ Yes ☐ 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)**



INDICATE MISSING TEETH WITH AN "X"

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 ☐ Will Be ☐ Have Been Performed.

*Signature of Dentist _____ Date Signed _____ Total Fee Actually Charged

43. Address where treatment was performed

Street _____ City _____ State _____ Zip _____

2. 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.

Detach and submit the completed Dental Expense Claim Form to:

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

Dentists' telephone: 1-877-638-3379

Fax: 1-859-389-6505

If you are submitting a claim, please complete and detach the first page only and mail it to the above address or fax it 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.