

## Dental Expense Claim

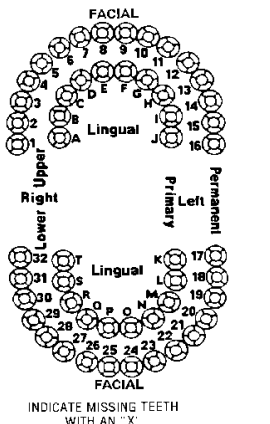
### To Be Completed by Member

1. Patient First Name _____ Middle _____ Last _____			2. Relationship to Member <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 <b>NYSUT Member Benefits Trust - 105643</b>			
11. Member First Name _____ Middle _____ Last _____				12. Member Date of Birth _____			13. Office Phone (Area Code) _____					
14. Member 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.  _____ Member Signature      Date _____				22. I Authorize Payment Directly to the Below-Named Dentist.  _____ Member 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 Herby Certify That The Services Listed Above <input type="checkbox"/> Will Be <input type="checkbox"/> Have Been Performed.			Total Fee Actually Charged	
*Signature of Dentist _____ Date Signed _____				
43. Address where treatment was performed Street _____ City _____ State _____ Zip _____				

# INSTRUCTIONS

Please Review These Instructions Before Submitting Claim.

## 1. FRAUD WARNINGS

Before completing this form, please read the following fraud 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 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.

**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, 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.

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

**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, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes 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 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.

**New York:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Oregon and 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.

**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.

**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 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 and subjects such person to criminal and civil penalties.

## INSTRUCTIONS (continued)

### 2. 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.

#### 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](http://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.

**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 թարգմանչապան 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 Կալիֆոռնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

**សេវាករំប្រដោយឥតគិតថ្លៃ ។** 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 ntauv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau pab ntauv 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 Iv-saws-las ntauv 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ることができます。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. **سرويس 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 معاوضه مترجم دی خدمات مل سکدی اے۔** تسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گربوتو، 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۔