

Please Review Before Submitting Claims

It is a **CRIME** to fill out this form with facts you know are false or to leave out facts you know are important.

Information for Employee _____

1. Complete items 1 through 15(a) in full to assure positive identification and prompt payment. Please print or type.
2. You can arrange for Metropolitan to make payment directly to the dentist by signing item 15(b). If you wish benefits to be paid directly to yourself, do not sign item 15(b). In either, case, a statement of benefits paid will be sent to you.
3. The *Patient* (or parent if patient is minor) must sign item 15(a).
4. If total charges for the planned course of treatment will be less than \$250, the claim form should be completed when treatment is completed, and mailed to the address shown below.
5. If total charges for the planned course of treatment can reasonably be expected to be \$250 or more, the form must be completed and submitted to Metropolitan *prior to the commencement of the course of treatment* for a pre-determination of benefits. Metropolitan will notify you and your dentist of the benefits payable.

Dental coverage is subject to specific limitations and exclusions. Please refer to your insurance booklet for a description of covered services, limitations and exclusions.

Information for Attending Dentist _____

1. Metropolitan will pay benefits equal to the dental fee charged up to the maximum amount listed in the schedule of Dental Services. A separate fee is required for each service.
2. If total charges for a course of treatment are less than \$250, check the box noted "Statement of Actual Services" and complete items 16 through 31 when treatment has been completed. The claim form should be sent to the address shown below.
3. If total charges for a course of treatment can reasonably be expected to be \$250 or more, check the box noted "Pre-Treatment Estimate" and complete items 16 through 31. For some procedures, supplementary pre-treatment information may also be required. The completed claim form, together with any required supplementary information should be submitted to Metropolitan prior to the commencement of the course of treatment.
4. Metropolitan will review the claim (and any supplementary information submitted) and notify you and your patient of the benefits payable.

Pre-determination of benefits is not intended to preclude a course of treatment agreed upon by you and your patient. The intent is to avoid any misunderstanding concerning the benefits payable under the terms of the coverage. Predetermination of benefits is not required for oral examinations, cleanings, fluoride applications, dental x-rays, or emergency treatment.

5. Generally, X-rays will not be required pre-operatively when restorative dentistry involving only standard filling material is utilized.

Diagnostic X-rays should be submitted only in connection with prosthetics, fixed bridgework, or cast restorations. Occasionally, we may request X-rays that relate to other dental services.

6. If the employee has so authorized, benefit payment will be made directly to you.

Mail Completed Form To:

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

For Claims Inquiry or Verification of Coverage Please Call 1-800-942-0854.