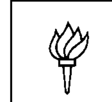
Dental Expense Claim Form



New York University
A private university in the public service

(Please Read Instructions on Reverse Side before Completing this Form)

TO BE COMPLETED BY EMPLOYEE

1. Patient First Name / Middle / Last
2. Relationship to Employee: Self / Spouse / Child / Other
3. Sex: M / F
4. Married: Yes / No
5. Patient Date of Birth: Mo / Day / Year
6. Group Number: **84542**
7. If Full Time Student (Age 19 or Over) School / City / State
8. EMPLOYEE SOC. SEC. NO.
9. If Disabled (Age 19 or Over) ☐ Yes ☐ No
10. Name of Group Dental Program: **New York University**
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 / Soc. Sec. No.
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.

Signed (Patient, or Parent if Minor) ______ Date ______

21. I Certify that the Above Information is Correct. **I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT. I KNOW THAT IF I DO THIS I ALSO MAY HAVE TO PAY A CIVIL PENALTY OF UP TO $5,000 PLUS THE VALUE OF THE CLAIM.**

Employee Signature ______ Date ______

22. I Authorize Payment Directly to the Below Named Dentist.

Employee Signature ______ Date ______

TO BE COMPLETED BY DENTIST

23. Dentist Name
24. Mailing Address

City, State, Zip

25. Dentist Soc. Sec. No. or T.I.N.
26. Dentist License No.
27. Dentist Phone No.
28. First Visit Date Current Series
29. Place of Treatment: Office / Hosp / ECF / Other
30. Radiographs or Models Enclosed? No / Yes / How Many?

	No	Yes	If Yes, Enter Brief Description and Dates
31. Is Treatment Result of Occupational Illness or Injury?			
32. Is Treatment Result of Auto Accident?			
33. Other Accident?			
34. Are any Services Covered by Another Plan?			
35. If Prosthesis, is this Initial Placement?			(If No, Reason For Replacement) — 36. Date of Prior Placement
37. Is Treatment for Orthodontics?			If Services Already Commenced, Enter — Date Appliance Placed — Mos. Treatment Remaining

Dentist's
☐ Pre-Treatment Estimate
☐ Statement of Actual Services
*(Be Sure To Sign Below)

38. Examination and Treatment Plan-List in Order From Tooth No. 1 Through Tooth No. 32
Use Charting System Shown

Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line No.	Date Service Performed Mo.	Day	Yr.	ADA Procedure Number	Fee	For Carrier Use Only
						Total Fee Actually Charged		

FACIAL

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
Lingual
Upper / Right / Lower — Primary / Left / Permanent
Lingual
T S R Q P O N M L K
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

FACIAL

INDICATE MISSING TEETH WITH AN "X"

I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed
I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT. I KNOW THAT IF I DO THIS I ALSO MAY HAVE TO PAY A CIVIL PENALTY OF UP TO $5,000 PLUS THE VALUE OF THE CLAIM.

*Signed (Dentist) ______ Date ______

Please Review 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 that item 8 (employee social security number) **must be completed** for the claim to be processed.
2. The **patient** (or parent if patient is a minor) must sign item 20.
3. You must sign the claim form in item 21.
4. You can arrange for Metropolitan 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 Metropolitan **prior to the commencement of the course of treatment** for a pretreatment estimate of benefits. Metropolitan 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 completed course of treatment are less than $300, check the box noted "Statement of Actual Services" and complete items 23 through 38. The claim form should then be sent to the address shown below.
3. If total charges for a course of treatment are expected to be $300 or more check the box noted "Pre-Treatment Estimate" and complete items 23 through 38). The completed claim form should be sent to Metropolitan **prior to the commencement of the course of treatment.** Metropolitan will review the claim (and any supplementary information required) and notify your patient of the benefits payable.

   A pretreatment estimate 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 dental plan. A pretreatment estimate is not necessary for oral examinations, cleanings, fluoride applications, dental x-rays, or emergency treatment.

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 payment will be made directly to you.

Mail completed form to: **MetLife**
Group Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Claim Inquiries: **1-800-942-0854**