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MetLife®
Metropolitan Life Insurance Company

Dental Expense Claim

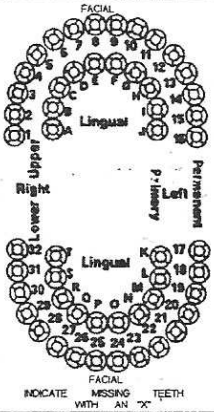
To Be Completed by Employee (You must review the important statements on page 2 and sign where indicated before completing this section of the form.)

1. Patient First Name Middle Last	2. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	3. Sex ☐ Male ☐ Female	4. Married? ☐ Yes ☐ 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. EMPLOYEE Social Security / 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 (Signature of Patient or Signature of Authorized Representative if Minor) Date / If Authorized Representative, Relationship to Minor	21. I Certify that the Above Information is Correct. 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 Social Security Number or T.I.N.	26. Dentist License Number	27. Dentist Phone Number
28. First Visit Date Current Series	29. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other	30. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many?
31. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	32. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	
33. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	34. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	
35. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement)		36. Date of Prior Replacement?
37. 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)**



38. 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	ADA Procedure Number	Fee	For Carrier Use Only

39. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed

*Signature of Dentist _____ Date _____ Total Fee Actually Charged

40. Address where treatment was performed

Street _____ City _____ State _____ Zip _____

Mail Completed Form to:

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

Employees: 1-800-942-0854
Dentists: 1-877-638-3379