Dental Expense Claim

MetLife®
Metropolitan Life Insurance Company

To Be Completed by Employee

1. Patient First Name / Middle / Last	2. Relationship to Employee	3. Sex	4. Married?	5. Patient DOB MM / DD / YYYY	6. For Office Use
	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	☐ Yes ☐ No		313500

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)	10. Name of Group Dental Program
		☐ Yes ☐ No	Barnes & Noble Education

11. Employee First Name / Middle / Last	12. Employee DOB MM / DD / YYYY	13. Daytime Phone (with 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. DOB MM / DD / YYYY	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 certify the above information is correct and authorize release of any information relating to this claim.	21. I authorize payment directly to the below named dentist.
(Signature of Patient or Signature of Authorized Representative if Minor) _____ Date _____	Employee Signature _____ Date _____
If Authorized Representative, Relationship to Minor _____	

To Be Completed by Dentist

22. Dentist Name	23. Mailing Address / City / State / Zip

24. Dentist Social Security Number or T.I.N.	25. Dentist License Number	26. Dentist Phone Number (with Area Code)

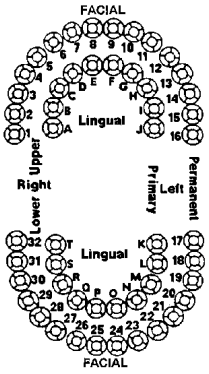
27. First Visit Date Current Series	28. Place of Treatment	29. Radiographs or models enclosed?
	☐ Office ☐ Hospital ☐ ECF ☐ Other _____	☐ Yes ☐ No How Many?_____

30. Is treatment result of occupational illness or injury? ☐ Yes ☐ No (If Yes, enter brief description and dates)	31. Is treatment result of auto accident? ☐ Yes ☐ No (If Yes, enter brief description and dates)
32. Other accident? ☐ Yes ☐ No (If Yes, enter brief description and dates)	33. Are any services covered by another plan? ☐ Yes ☐ No (If Yes, enter brief description and dates)

34. If prosthesis, is this initial placement? ☐ Yes ☐ No (If No, reason for replacement)	35. Date of prior placement?

36. 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"

37. 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
38. I Hereby Certify that the Services Listed Above ☐ Will Be ☐ Have Been Performed				Total Fee Actually Charged		

* Signature of Dentist _____ Date _____

39. Address where treatment was performed.

Street _____ City _____ State _____ Zip _____

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.

For MetLife use only below this line

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: Item 8 (Employee Social Security / 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 operation, 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 item 20.
4. You can arrange for MetLife to make payment directly to the dentist by completing item 21. If you wish benefits to be paid directly to yourself, do not complete item 21. 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 $200 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 $200.)
6. If total charges for the planned course of treatment will be less than $200, 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 course of treatment are expected to be $200 or more, check the box noted **"Pretreatment Estimate"** and complete items 22 through 38. 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 than the mailing address in item 23, complete item 39.
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.

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