CLAIM SUBMISSION INFORMATION

Please Review These Instructions Before Submitting Claim

Information for Sponsor/Patient

1. Complete your section of the claim submission document (items 1 through 20) in full to assure positive identification and prompt payment. Please print or type. Note: Item 7 (Sponsor SSN or DBN) must be completed for the claim to be processed.
2. Patient Consent. By signing item 19, 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 19.
3. You must sign the claim submission document in item 20.

4a. For OCONUS dentists in the TOPD program (TRICARE OCONUS Preferred Dentists) MetLife will make payment directly to the dentist. If you wish benefits to be paid directly to yourself, do not complete item 21 and receipt for services rendered must accompany the claim form at time of submission.

4b. 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. A pretreatment estimate is recommended for treatment plans involving onlays, single crowns, implants, prosthodontics, periodontics, orthodontics, and oral surgery services. This allows the dentist and the beneficiary to know, prior to receiving treatment, if the proposed service(s) will be covered by MetLife and the anticipated amount of payment. The completed claim submission document should be sent to the address below prior to the commencement of the course of treatment. MetLife will notify you of your benefits payable.
6. For orthodontic care, you or your dentist should submit a copy of this claim submission document along with a valid Non-Availability and Referral Form (NARF) to the address 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. It is important that a separate fee is indicated for each item of service performed.
2. A pretreatment estimate is recommended for treatment plans involving onlays, single crowns, implants, prosthodontics, periodontics, orthodontics, and oral surgery services. The completed claim submission document should be sent to the address 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 23, complete item 38.
4. Sections 22-38 do not need to be completed as long as the bill submitted contains all the pertinent information. The bill needs to include the treatment information - date of service, fee, procedure code, description of services rendered, including applicable tooth number where appropriate, the providers name, address, phone number and signature of treating dentist.
5. If you are a TOPD (TRICARE OCONUS Preferred Dentist), payment will be made directly to you unless the patient/sponsor submits receipt for services rendered. In that case, payment will be made to the patient/sponsor.

Mail or fax the completed Dental Expense Claim Submission Document to:

MetLife TRICARE Dental Program
PO Box 14182
Lexington, KY 40512

Dentists: 1-855-638-8372 (1-855-MET-TDP2)

Fax number: 1-855-763-1334
Email: OCONUSDentalClaims@metlife.com

MetLife®
Metropolitan Life Insurance Company

Dental Expense Claim for OCONUS (outside the Continental United States)

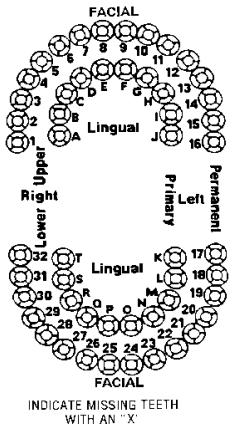
To Be Completed by Sponsor

1. Patient First Name Middle Last	2. Relationship to Sponsor ☐ Self ☐ Spouse ☐ Child ☐ Other	3. Sex ☐ Male ☐ Female	4. Patient Date of Birth Mo. / Day / Year	5. For Office Use
6. If Full-Time Student (Age 19 or Over) School City State	7. Sponsor SSN or DBN	8. If Disabled (Age 19 or Over) ☐ Yes ☐ No	9. Name of Group Dental Program TRICARE Dental Program (TDP)	
10. Sponsor First Name Middle Last	11. Sponsor Date of Birth	12. Home Phone (Country, City, and/or Area Code)		
13. Patient Residence Mailing Address (APO/FPO or Street)	14. City, State, Country, Postal Mailing Code			
15. Are other Family Members Employed? ☐ Yes ☐ No Name Social Security / ID Number	16. Date of Birth	17. Name and Address of Employer for Item 16		
18. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:) Dental Plan Name Group No. Name and Address of Carrier				
19. 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	20. I Certify that the Above Information is Correct. _____ Patient Signature _____ Date	21. I Authorize Payment Directly to the Below-Named Dentist. _____ Patient Signature _____ Date		

To Be Completed by Dentist

22. Dentist Name	23. Mailing Address City State Country Postal Mailing Code		
24. Dentist Phone Number (country, city, and/or area code)	25. Dentist License Number	26. First Visit Date Current Series	27. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other_____
28. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		29. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	
30. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		31. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	
32. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement)			33. Date of Prior Replacement
34. Is Treatment for Orthodontics? ☐ Yes ☐ No	If Services Already Commenced, Enter Date Appliance Placed (Non-Availability and Referral Form Necessary)		Months of Treatment Remaining

Dentist's – ☐ Pretreatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)** | 35. Is the Patient currently ☐ Diabetic ☐ Pregnant?



INDICATE MISSING TEETH WITH AN "X"

36. 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 Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day /Year	ADA Procedure Number	Fee	For Carrier Use Only

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

*Signature of Dentist _____ Date Signed _____ Total Fee Actually Charged

38. Address where treatment was performed

Country _____ Street _____

City _____ State _____ Postal Mailing Code _____