Group Name: BRANDYWINE SCHOOL DISTRICT

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. Group Dental Program
			120528

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	21. I Certify that the Above Information is Correct.	22. I Authorize Payment Directly to the Below Named Dentist.
(Signature of Patient or Signature of Authorized Representative if Minor) Date If Authorized Representative, Relationship to Minor	Employee Signature Date	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?

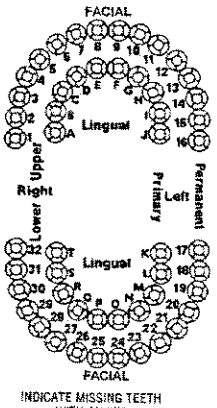
31. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	32. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)

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)**



INDICATE MISSING TEETH WITH AN "X"

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 Mo./Day/Year	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 _____