MetLife
Metropolitan Life Insurance Company

Dental Expense Claim

To Be Completed by Employee

1. Patient First Name / Middle / Last	2. Relationship to Employee	3. Sex	4. Married?	5. Patient Date of Birth Mo. / Day / Year	6. For Office Use
	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	☐ Yes ☐ No		

7. If Full-Time Student (Age 19 or Over) School / City / State	8. 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.	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
Scott H. Leaf, D.D.S.	**9316-C Old Keene Mill Road**	**Burke**	**Virginia**	**22015**

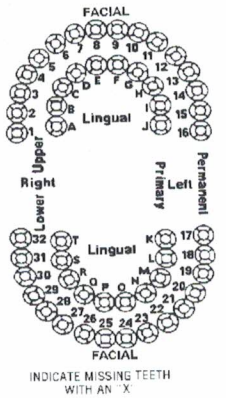
25. Dentist Phone Number	26. Dentist License Number	27. Dentist SSN or T.I.N.	28. Provider Specialty Code	29. NPI (Treating Dentist)
703-455-9683	**401005821**	**27-0773127**	**1223PO221X**	**1346457983**

30. NPI (Billing Entity, if different)	31. First Visit Date Current Series	32. Place of Treatment	33. Radiographs or Models Enclosed?
		☒ Office ☐ Hospital ☐ ECF ☐ Other _____	☐ Yes ☐ No How Many? ____

34. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	35. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)
36. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)	37. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)

38. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement)	39. Date of Prior Replacement
40. 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)**



41. 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

42. I Hereby Certify That The Services Listed Above ☐ Will Be ☒ Have Been Performed.
*Signature of Dentist _____ Date Signed _____ Total Fee Actually Charged

43. Address where treatment was performed
Street **9316-C Old Keene Mill Road** City **Burke** State **Virginia** Zip **22015**