



APPLICATION FOR PREVENTIVE PLUS

(Program for Special Dental Risks)



(Please Read Instructions On Following Page Before Completing This Form.)

This is not a claim form.

TO BE COMPLETED BY EMPLOYEE

1. Patient First Name Middle Last			2. Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		3. Sex <input type="checkbox"/> M <input type="checkbox"/> F	4. Married <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Patient Date of Birth	6. Report Number 34701
7. City State Zip			8. EMPLOYEE SOCIAL SECURITY / ID NUMBER		9. If Disabled (Age 23 or Over) <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Name of Group Dental Program MCHCP	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No Name Soc. Sec. No.			17. Date of Birth		18. Name and Address of Employer for Item 16			
19. Is Patient Covered by Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Complete the Following)			Dental Plan Name		Group No.		Name and Address of Carrier	
20. I Authorize My Dentist/Physician to Release All Information Necessary to Process This Application for Preventive Plus. Signed (Patient, or Parent/Guardian if Minor) _____ Date _____				21. I Certify that the Above Information is Correct. Employee Signature _____ Date _____				

TO BE COMPLETED BY PROVIDER

22. Dentist/Physician's Name			27. NPI (Treating Provider)		28. NPI (Billing Entity, if different)		
23. Mailing Address City, State, Zip			29. Medical condition of the above patient requiring additional preventive services <input type="checkbox"/> Pregnancy, expected delivery date _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Supressed Immune System <i>* Please refer to item 4 under "Eligibility Process" on the following page for additional details.</i>				
24. Provider Soc. Sec. No. or T.I.N.	25. Provider License No.	26. Office Phone No.					
30. Detailed description of why more frequent preventive services beyond those covered under the MCHCP Dental Plan are required: _____ _____ _____ _____ _____							
31. I Hereby Certify That The Patient Above Should Be Considered For Enrollment In MetLife's Preventive Plus Program (Described on the following page of this application). Signed (Dentist/Physician) _____ Date _____ Print Name _____							

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

MAIL TO: METLIFE DENTAL CLAIMS, 5950 AIRPORT ROAD, ORISKANY, NY 13424. TELEPHONE: 1-844-222-9106 FAX: 1-315-792-6857

For use by MetLife	
Date Received in Claim Office _____	Date Patient File Noted by Approver _____
Date Reviewed by Consultant _____	Date for Next Review _____
Consultant Reviewed By _____	Name of Approver _____

Please Review Before Submitting Application

Preventive Plus Program Description

Clinical research shows that some medical conditions can negatively impact dental health. Some of these conditions include pregnancy, diabetes and a suppressed immune system. People with these conditions should take extra care of their teeth through more frequent cleanings and other preventive dental measures. To assist members of MCHCP who may fall into these risk categories, MetLife has developed a program of oral disease management designed to screen and provide targeted, medically necessary preventive care benefits. Covered members of MCHCP who are pregnant, have diabetes, or have a suppressed immune system, can qualify to receive coverage for additional dental services. These services may include additional dental check-ups, cleanings, and other preventive measures that are medically necessary and would otherwise be limited by age or frequency under the current MCHCP Dental Plan.

Eligibility Process

1. Patient must be covered under the MCHCP Dental Plan.
2. Complete and submit Preventive Plus Application to MetLife at the address below. **PLEASE DO NOT SEND PREVENTIVE PLUS APPLICATIONS TO METLIFE'S P.O. BOX IN KENTUCKY.**
3. Necessary clinical information must be provided by your dentist/physician. Based on the clinical information provided by your dentist or the presentation of information from your physician (e.g., confirming diabetes, pregnancy, etc.), MetLife will determine if the applicant qualifies for acceptance into the Preventive Plus Program.
4. MCHCP and MetLife are aware that other medical conditions may cause an increase in risk to oral health. These conditions will be evaluated by MetLife and may make the applicant eligible to participate in the Preventive Plus Program. Each request for entry into Preventive Plus for medical conditions not identified on this Application must be submitted to MetLife using this form. A complete explanation must appear in item 30 of this Application.
5. MetLife will make all determinations in writing.
6. If denied, covered individual may appeal in writing using normal MCHCP procedures.

Applicants approved for the program will submit claims to MetLife on the standard MCHCP Dental Claim Form. No special claim form is necessary. Assigned claims submitted by an applicant's dentist will also be accepted through normal methods. Preventive claims that would otherwise have been declined by MetLife due to limitations and exclusions under the MCHCP Dental Plan will be considered for payment under Preventive Plus.

How to Complete This Application

1. Complete your section of the application (items 1 through 21) in full. Please print or type. Note that item 8 (Employee Social Security / ID Number) **must be completed** for the application to be processed.
2. The **patient** (or parent/guardian if patient is a minor under age 18) must sign item 20.
3. Employee must sign item 21.

Information for Attending Dentist/Physician

1. Your patient may be eligible for preventive dental benefits currently covered under the MCHCP Dental Plan. For details about MCHCP dental benefits, contact MetLife at 1-844-222-9106. Representatives at this number can also answer questions about Preventive Plus. **Preventive Plus is not covering procedures already excluded by the MCHCP Dental Plan. Instead, Preventive Plus covers existing services with enhanced frequency limits.**
2. Acceptance of a covered member into the Preventive Plus Program is no guarantee that additional benefits will be paid by MetLife.
3. It is recommended that all additional treatment for which coverage may be eligible under Preventive Plus be submitted to MetLife in advance as a pre-treatment estimate. Please use MetLife's standard dental claim form for this purpose.
4. Please complete sections 22 – 30, and sign and date item 31.

Mail completed Preventive Plus Application to:

MetLife Dental Claims
5950 Airport Road
Oriskany, NY 13424

or Fax Applications to:

1-315-792-6857

For Inquiries Call:

1-844-222-9106