MetLife

Dental HMO Continuing Orthodontic Treatment Request Form

If you or one of your enrolled dependents is currently in active orthodontic treatment under your company/organization's prior dental plan, please complete and submit this form for coverage determination with your current orthodontist (participating or non-participating with SafeGuard).

This service is only available to you and your covered dependents if:

- **this request form is received by SafeGuard within thirty (30) days of the plan's effective date,**
- **currently covered by your company/organization's prior plan, which must have coverage for orthodontia, and**
- **currently under active orthodontic treatment.**

Please ensure both sections of this form are complete — **Subscriber Information** and **Orthodontist Information** — and required documentation — **Evidence of Payment and Provider Claim Form** — is provided. **Evidence of Payment** documentation, available from your orthodontist, is required to show the original amount of the contract fee for your orthodontic treatment and what has been paid to date. Additionally, the orthodontist must include a claim form showing the amount of payments that has been received from the prior dental plan carrier as well as the outstanding balance owed.

The completed form and all necessary documentation must be received by SafeGuard within thirty (30) days of the Plan's effective date to allow orthodontic coverage to be considered for coverage by SafeGuard and avoid delays in payment. Incomplete requests will be returned to the Subscriber's address provided below, for required information.

Subscriber Information (to be completed by the subscriber)

Subscriber's Name	Subscriber's Social Security Number
Subscriber's Street Address (Apt. # if applicable)	
Subscriber's City, State, Zip	Subscriber Telephone Number ( )
Company/Organization Name	Previous Dental Carrier
Subscriber Signature	Patient's Name (see policies for eligibility above)

Orthodontist Information (to be completed by patient's current orthodontist)

Orthodontist Name	Telephone Number ( )	Taxpayer Identification Number
Street Address		City, State, Zip
Patient's Initial Banding Date (beginning of active treatment)	Initial Treatment Term & Remaining Months of Treatment	Prior Carrier Agreed-Upon Full Case Amount $
Total Ortho Case $	Amt paid to date – by patient $	Amt paid to date – by prior carrier $

ALL INFORMATION IS REQUIRED IN ORDER TO PROCESS THIS REQUEST

Upon receipt of the completed form, with all supporting documentation, SafeGuard will accept liability for continuing payment of the remaining balance owed, up to a maximum of $1,500 times the percentage of the total orthodontic treatment remaining as of this group Plan's Effective Date, subject to the section titled DENTAL BENEFITS: LIMITATIONS AND ADDITIONAL CHARGES and DENTAL BENEFTITS: EXCLUSIONS in the Plan's Schedule of Benefits.

Dental HMO plans are available in CA, FL and TX only, through a domestic company in the applicable state named SafeGuard Health Plans, Inc. The SafeGuard companies are part of the MetLife family of companies. "Dental HMO" is used to refer to products that may differ by state of residence of the enrollee, including but not limited to: "Specialized Health Care Service Plans" in California; "Prepaid Limited Health Service Organizations" as described in Chapter 636 of the Florida statutes in Florida; and "Single Service Health Maintenance Organization" in Texas.

Please return this form to: SafeGuard Claims Department, P.O. Box 981987, El Paso TX 79998.