ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [X] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
   METLIFE
   PO BOX 981282
   EL PASO, TX 79998

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    ELLIS, KEVIN
    3720 BEESON DAIRY RD
    WINSTON SALEM, NC 27105-9778

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
04/08/1966	[X] M [ ] F	249154559

16. Plan/Group Number	17. Employer Name
112815	LEGGETT PLATT, INC.

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [X] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
   JULIE ELLIS

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
01/05/1969	[ ] M [X] F	240175290

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
305584	[ ] Self [ ] Spouse [X] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
    METLIFE
    PO BOX 981282
    EL PASO, TX 79998

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: [ ] Self [ ] Spouse [X] Dependent Child [ ] Other
19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    ELLIS, KELSEY
    3720 BEESON DAIRY RD
    WINSTON SALEM, NC 27105-9778

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
01/16/2003	[ ] M [X] F	805065yyPREVIEW

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	2016/12/15					D8670			PERIOD ORTHO TX INSTALLMENT	84.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____
31a. Other Fee(s)
32. Total Fee 84.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X SIGNATURE ON FILE — Patient/Guardian Signature — 12/15/2016 — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X SIGNATURE ON FILE — Subscriber Signature — 12/15/2016 — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [X] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY) 12/1/2015
42. Months of Treatment 12
43. Replacement of Prosthesis [ ] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
    Kenneth M. Sadler, DDS and Associates, PA
    201 Charlois Boulevard
    Winston-Salem, NC 27103

49. NPI	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number (336) 331-3500
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Dr Deborah F Novak — Signed (Treating Dentist) — 12/15/2016 — Date

54. NPI 1457441420
55. License Number
56. Address, City, State, Zip Code
    201 Charlois Blvd
    Winston-Salem, NC 27103
56a. Provider Specialty Code 1223X0400X
57. Phone Number (336) 331-3500
58. Additional Provider ID