

Claim for temporary emergency dental treatment in the UK with a dentist who is not acting on behalf of your dentist

Supplementary Insurance/Denplan Emergency – Benefit A

Denplan Care, Denplan Essentials, Membership Plan and Plans for Children patients are not entitled to reimbursement for temporary emergency treatment from their registered dentist or a dentist who is connected with their own dentist, or received treatment within 40 miles from home.

Before completing this form please read the terms and conditions of your policy document. To help us settle your claim quickly please answer all questions as accurately as you can and write clearly in BLOCK CAPITALS using black or blue ink.

Please make reasonable efforts to ask your dentist to complete the information required concerning any treatment and advice that you've received. If there is any difficulty in doing this, do not delay in returning the form to us.

Office use only. Claim reference number.

INS01 / 01-10

If you've any questions please call a member of our insurance team free from a UK landline on 0800 085 0960. Please send your completed form, within 60 days of the incident where reasonably possible, to us at Insurance Department, Denplan Limited, Denplan Court, Victoria Road, Winchester, Hampshire, SO23 7RG.

Patient details

To be completed by the patient (or parent/guardian of a patient under 16 years)

Which Denplan product are you registered on?

Denplan Care Denplan Essentials Membership Plan Plans for Children Denplan Emergency

What is your Denplan registration number?

Mr Mrs Miss Other Male Female Date of birth

First name

Surname

House name or number

Address

Town or city

County Postcode

Is this your permanent address? Yes No

Home phone number Work phone number

Email address

We may use this email address to advise you of confidential information regarding your insurance claim. If you would prefer not to be contacted in this way, please don't provide your email address.

Have you made any previous claims under this Supplementary Insurance/Denplan Emergency policy? Yes No

Treating dentist's details

To be completed by the treating dentist

Dentist's Denplan Membership number (E.g. 251403) GDC number (if not a Denplan member)

Mr Mrs Dr Miss Ms Other

First name

Surname

Practice name

Practice address

Town or city

County Postcode

Practice phone number

Do you have a Denplan Care Contract with this patient? Yes No If 'No' are you connected* with the patient's Denplan Dentist? Yes No

*E.g. Partner, expense sharing colleague, associate, locum or part of the same rota.

Please give a description of treatment/consultation given

Details of temporary emergency treatment (excludes permanent)

To be completed by the patient (or parent/guardian of a patient under 16 years)

What was the date and time of the treatment/consultation? Time : AM PM

Was this arranged through the Denplan Emergency Helpline? Yes No

Helpline referral number (if you were provided with one)

What was the dental problem and what treatment did you receive?

Has the dentist been paid? Full payment Part payment I have not paid

If the treatment has been paid in part or in full please attach fully itemised receipts and indicate how much you paid? Amount £

If you've not paid do you want Denplan to pay the practice/dentist directly? Yes No

Patient's declaration

To be completed by the patient (or parent/guardian of a patient under 16 years)

I confirm that I am the patient (patient's parent or guardian if under 16 years of age) and I declare that all the information provided on this form is true and complete. I hereby authorise any dentist or person who has examined me/the patient to provide Denplan Ltd, or its representatives, with any information concerning the above matters to support this claim. I understand that Denplan Ltd, on behalf of the Insurers, reserves the right to appoint an examiner or make such other enquiries as it considers appropriate before agreeing any claim.

Patient (parent/guardian) name

Patient (parent/guardian) signature

Date

Treatment codeTo be completed by the treating dentist – please see your Policy Document for full details
Please complete the number of items in the boxes below

Quantity

1	<input type="text"/>	Examination and report to include all necessary smoothing, stoning and occlusal adjustments
2	<input type="text"/>	Radiographic examination
3	<input type="text"/>	Extraction of up to 2 teeth
4a	<input type="text"/>	Root canal extirpation to include dressings and/or temporary fillings and necessary prescriptions (incisors/canines)
4b	<input type="text"/>	As 4a – two canals
4c	<input type="text"/>	As 4a – three or more canals
5	<input type="text"/>	Treatment of dental infection to include any necessary prescriptions
6a	<input type="text"/>	Provision of temporary filling, first tooth
6b	<input type="text"/>	Provision of temporary filling, additional teeth
7	<input type="text"/>	Recement crown or inlay
8	<input type="text"/>	Recement bridge
9	<input type="text"/>	Construction and fitting of temporary crown
10a	<input type="text"/>	Construction and fitting of temporary bridge
10b	<input type="text"/>	Provision of temporary post and core per tooth
11	<input type="text"/>	Arrest of abnormal haemorrhage including aftercare and associated suture removal
12	<input type="text"/>	Removal of sutures placed by another practitioner
13	<input type="text"/>	Repair/adjustment of orthodontic appliance
14	<input type="text"/>	Adjustment to denture
15	<input type="text"/>	Repair of denture to include refixing of teeth and gums and repair of clasp
16	<input type="text"/>	Any other temporary treatment, please specify <input type="text"/>

If claiming a **call-out fee** tick one box below (the fee payable will exclude the patient's liability).
Please note that only one fee can be claimed in this section.

Was it necessary to re-open your surgery? Yes No

Call out fee

30a	<input type="radio"/>	Weekdays 6am - 8am and 6pm - 10pm	30c	<input type="radio"/>	Night visit 10pm - 6am	30e	<input type="radio"/>	Christmas	30f	<input type="radio"/>	Boxing day	30h	<input type="radio"/>	New Year
30b	<input type="radio"/>	Weekends & Bank Holidays 6am - 10pm	30d	<input type="radio"/>	Domiciliary visit for emergency treatment (only two allowed per policy year)	30g	<input type="radio"/>	New Years Eve after 6pm						

Telephone consultation

31a	<input type="radio"/>	Weekdays and weekends 6am - 10pm	31b	<input type="radio"/>	Weekdays and weekends 10pm - 6am
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Dentist's declaration

I declare that the information I have given on this form is correct.

Dentist's name

Dentist's signature (if no receipt attached by patient)

Date

Payment details

Please tick the box to indicate your preferred method of payment

Please ensure that you complete this section fully. We may return the claim form to you if this not completed.

Please make payment for this claim by:

Cheque payable to (if practice/dentist to be paid directly)

Direct credit to the account details held under the Denplan membership number stated overleaf

Denplan Limited, Denplan Court, Victoria Road, Winchester, SO23 7RG, UK

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**Denplan**
At the heart of dental care