

Claim/application for authorisation to treat a dental injury worldwide

Supplementary Insurance/Denplan Emergency – Benefit B

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.

Link number.

INS02 / 04-10

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 completion of your dental treatment 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 Please be aware that dental records may be required to support your claim.

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

Country Postcode

Practice phone number

Details of your dental injury

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

How did the dental injury occur?

What was the date and time of your dental injury? Time : AM PM

What dental injury did you notice within the first 7 days?

If your dental injury occurred while participating in any form of contact sport (including training), were you wearing a mouth guard? Yes No

Please provide the name(s) of any witnesses

Are you covered by, or claiming under, any other insurance in relation to this incident? Yes No

If 'Yes' please give details

Was the incident reported to any other authority (eg. police or employer)? Yes No

If 'Yes' please give name, address and any reference of authority to which the report was made

Do you want Denplan to pay the practice/dentist directly? Yes No If 'No', please send us the dentist's account on completion of your treatment.

Are you applying for authorisation for treatment by a dentist who is NOT your Denplan dentist? Yes No

If 'Yes' please tell us why you wish treatment to be carried out by a dentist who is not your Denplan dentist

I understand that the Insurer retains the right to recover any incurred costs as a result of a third party's involvement.

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 the dental injury of which details are given was caused by direct external impact and all the information that I have provided on this form is true and complete. I understand that the Insurer retains the right to recover any incurred costs as a result of a third party's involvement. I hereby authorise any dentist or person who examined me/the patient to provide Denplan Ltd, or its representatives, with any information or dental records 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 details

To be completed by the treating dentist

What restorations were in place on the damaged teeth prior to the accident?

Please give details of damage to the dentition

What date did the treatment start?

D D M M Y Y Y Y

Please give details of treatment carried out so far

Please give details of the proposed plan for future dental treatment

When was the treatment completed?

D D M M Y Y Y Y

Treatment code

To be completed by the treating dentist – please see your Policy Document for full details
Please complete the number of items and your normal fee in the boxes below

Quantity			Quantity		
17	£	Examination and report to include all necessary smoothing, polishing and vitality testing	27a	£	Permanent acrylic denture
18	£	X-rays	27b	£	Permanent metal denture
19a	£	Porcelain jacket crown	27c	£	Temporary denture following tooth loss (where required)
19b	£	Dentine bonded crown	28a	£	Laboratory made temporary bridge following tooth loss (where required)
20a	£	Metal bonded porcelain crown	28b	£	Laboratory made temporary bridge following tooth loss (additional units)
20b	£	Post/core construction	29	£	Emergency and other treatment following dental injury not otherwise specified
21a	£	Metal bonded porcelain bridgework – retainer			
21b	£	Metal bonded porcelain bridgework – pontic			
22	£	Full metal crown			
23a	£	Ziroconia crown			
23b	£	Ziroconia bridge unit			
24a	£	Laboratory constructed adhesive bridge – retainer	34	£	Implant (Please note that this is only available for patients with Implant Upgrade Cover. If implants are required please submit four years dental records and x-rays to support your claim)
24b	£	Laboratory constructed adhesive bridge – pontic			
25	£	Laboratory constructed adhesive facing or veneer			
26a	£	Root canal treatment – incisor (includes filling of access cavity)			
26b	£	Root canal treatment – canine (includes filling of access cavity)			
26c	£	Root canal treatment – premolar (includes filling of access cavity)			
26d	£	Root canal treatment – molar (includes filling of access cavity)			

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

Date D D M M Y Y Y Y

Time : AM PM

Call out fee

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

Telephone consultation

- 31a Weekdays and weekends 6am - 10pm
- 31b Weekdays and weekends 10pm - 6am

Payment details

Please tick the box to indicate your preferred method of payment

Please ensure that you complete this section fully. If left blank, we will assume that the cheque is to be made payable to the treating dentist. 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

Treating dentist's declaration

I declare that the dental injury sustained by this patient is consistent with an external impact and confirm that the information I have given on this form is correct.

Dentist's name

Dentist's signature (if no receipt attached)

Date

X

D D M M Y Y Y Y

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

Tel: +44 (0) 1962 828000. Fax: +44 (0) 1962 840846. Email: denplan@denplan.co.uk

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Denplan
At the heart of dental care

Once Denplan has authorised treatment this slip will be returned to you with a treatment authorisation letter.

When permanent treatment has been completed please sign and return this slip in the pre-paid envelope to ensure we can settle the eligible claim quickly.

Office use only. Claim reference number.

Patient's declaration

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

I declare that the treatment has been completed.

Patient (parent/guardian) name

Patient (parent/guardian) signature

Date

X

D D M M Y Y Y Y

What is your Denplan registration number?

Treating dentist's declaration

I declare that the treatment has been completed.

Dentist's name

Dentist's signature

Date

X

D D M M Y Y Y Y

Denplan Membership Number (if applicable)



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