Claim for out of hours dental emergency or telephone consultation

Supplementary Insurance/Denplan Emergency – Benefit C

Office use only. Claim reference number.

INS06 / 01-10

This form is to be used when the dentist's surgery has to re-open to treat a patient outside the practice's normal working hours (within specified times) or for a telephone consultation.

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.

If you've any questions please call a member of our insurance team free from a UK landline 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 D D M M Y Y Y Y

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

Country

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.

Claim for emergency call-out

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

What was the date and time of your treatment/consultation? D D M M Y Y Y Y Time : AM PM

Was this arranged through the Denplan Emergency Helpline? Yes No

If 'No' at what time did you contact the surgery? Time AM PM

What was your 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

Treatment code

To be completed by the treating dentist – please see your Policy Document for full details
Please tick relevant treatment code box(es)

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 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

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) ✗

Date D D M M Y Y Y Y

Payment details

Please tick the box to indicate your preferred method of payment

Please ensure that you complete this section fully.
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

Patient's declaration

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 D D M M Y Y Y Y

Denplan Limited, Denplan Court, Victoria Road, Winchester, SO23 7RG, UK
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At the heart of dental care