Claim for out of hours dental emergency or telephone consultation

Supplementary Insurance/Denplan Emergency – Benefit C

Denplan
Part of Simplyhealth

Before completing this form please read the terms and conditions in your policy document. To help us settle your claim quickly please complete all sections and write clearly in BLOCK CAPITALS using black or blue ink.

Please be aware we may need your dental records to support your claim.

If you've any questions please call call 0800 0850 960, or email DenplanClaimForms@simplyhealth.co.uk
Please send your completed form, within 60 days of the incident where reasonably possible, to us at Denplan, part of Simplyhealth, Hambleden House, Waterloo Court, Andover, SP10 1LQ.

Patient details

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

Registration number

Mr ○ Mrs ○ Miss ○ Other ○ Date of birth D D M M Y Y Y Y

First name Surname

House name or number

Address

Town/City Postcode

Home phone number Mobile phone number

Email address

We may use this email address to advise you of confidential information about your insurance claim. If you would prefer not to be contacted in this way, please leave this box blank.
If you would prefer to receive your regular correspondence by email, please tick ○

Treating dentist's details

If the dental practice are unavailable to complete this section, please add in as much information as you know

Dentist's registration facility number (e.g. 251403/a) / (Last character should be a letter)

GDC number (if not a Denplan member)

Mr ○ Mrs ○ Dr ○ Miss ○ Ms ○ Other

First name Surname

Practice name

Practice address

Town/city 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?

Please turn over

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 ○

30a Weekdays 6am-8am and 6pm-10pm ○ 30b Weekends and Bank Holidays 6am-10pm ○ 30c Nights 10pm-6am ○

30d Christmas Day ○ 30e Boxing Day ○ 30f New Year's Eve after 6pm ○ 30g New Year's Day ○

30h Domiciliary visits up to two per year, payable within a practice's normal working hours (where available) ○

Telephone consultation (where no attendance follows)

31a 6am-8am and 6pm-10pm weekdays, 6am-10pm weekends and bank holidays ○ 31b Weekdays and weekends 10pm-6am ○

Payment details

Dentist or patient to complete. Please tick the box to indicate your preferred method of payment

Please ensure that you complete this section fully.

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 £

Who would you like us to pay? Patient ○ Dentist ○

○ Direct credit to the account details held under the dentist Denplan membership / (the last box should contain a letter)

○ Direct payment into the bank account we debit your monthly subscription from

Or

○ Cheque payable to

Patient's declaration

If you're a dentist claiming a telephone consultation this does not need to be completed

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

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