

DENTAL CLAIM FORM

IMPORTANT

PLEASE COMPLETE ONE CLAIM FOR EACH PATIENT

- Your policy document will tell you whether or not you can make a claim.
- Make sure you answer all the questions on this form; otherwise it will delay your claim.
- Please ensure that you provide original detailed receipts.
- You must complete and submit the claim form within 30 days of the dental treatment, even if you are on a long term treatment plan.

OFFICE USE ONLY – CLAIM NO.

A Policyholder Details

Policy Number

Title Mr. Mrs. Miss Ms. Other

First Name(s)

Surname Date of Birth / /

Address

 Post Code

Home Telephone No.

Mobile Telephone No.

E-mail Address

B Patient Details (if different to Policyholder)

Title Mr Mrs Miss Ms Other

First Name(s)

Surname

Date of Birth / /

Relationship to you

C Registered Dentist Details

Name of Dentist you are registered with Practice Type:
 NHS
 Private

Practice Name

Address

 Post Code

Telephone No.

NOTE - You need to have been seen by a dentist in the 12 months before the Start Date in order to be covered for dental treatment. If that dentist is not the dentist above please provide details in Section F of the claim form.

D Dental Practice Receipt (for completion by Dentist)

Please attach the original itemised receipt(s)

I certify that I supplied dental treatment to:

Patient's Name on: / / Date patient first registered at the practice: / / Date of last check-up: / / Date treatment first identified as being medically necessary: / / **PLEASE COMPLETE THE FOLLOWING SECTIONS IF APPLICABLE:**
 DENTAL ACCIDENT £
 A sudden and unexpected injury to the mouth which causes damage to teeth and/or gums and results from direct violent means.

 EMERGENCY DENTAL TREATMENT * £
 Initial visit only for the immediate relief of severe pain, the inability to eat, arrest of haemorrhage, control of acute infection or which causes a severe threat to your general health.

* *Emergency dental treatment is classed as treatment that must be provided out of hours by a dentist other than your normal dentist as a result of you being more than 25 miles by road from your normal dentist when the emergency occurs. Any subsequent treatment required or received is excluded unless cover is specifically provided for under another section of the policy.*

If emergency dental treatment is provided, please tick where the below statements are correct. Please note for valid cover all must be ticked.

- Treatment was not performed by patient's normal dentist
- Treatment was provided out of hours
- Treatment was provided more than 25 miles by road from patient's normal dentist

TREATMENT CLAIM FOR:

CATEGORY	TREATMENT	QUANTITY	TOTAL NHS COSTS (£)	TOTAL PRIVATE COSTS (£)
CHECK-UPS	Examination			
	Scale/Polish			
	X-Ray			
TREATMENT	Filling			
	Crown			
	Bridge			
	Mouth Guard			
	Root Canal			
	Surgical Extraction			
EMERGENCY	Emergency Dental Treatment			
	Dental Accident Cover			
	Oral Cancer			
TOTAL			£ <input type="text"/>	£ <input type="text"/>

** Dentist Signature XDentist Name

** This must be signed by the dentist not a practice representative

Practice Telephone

Dentist's Practice Stamp

Date / / **E Declaration and Authority**

I declare that the statements I have made are true and agree that if they are found to be untrue, I will lose all my rights under the policy. I authorise Red Sands and any of its representatives to make any enquiries and obtain any information they may consider relevant from me, my dentist, or elsewhere. I understand that my personal information will be held on computer or other files by Red Sands, any associated company or agent for the purposes of administering this insurance, including carrying out customer surveys, claims handling and fraud prevention. I consent to my personal information being disclosed to Direct Group Limited under the agreement with which I took out with this insurance, and also to other insurers via a register of claims used by the insurers to stop people making dishonest claims. (A list of insurers who take part in the scheme is available on request).

I understand that it is my responsibility to give all necessary information to the Tax Authorities and to meet any tax demands I may have from my claim being paid.

Signature XDate / /

F Previous Dentist History

If you are required to provide previous dentist history as per the requirement detailed in Section C, please complete the below sections:

Name of Dentist you were previously registered with

Practice Name

Address

Post Code

Telephone No.

Date of last check-up:

G Next Steps

PLEASE CHECK:

- You have provided the policyholder details in section (A)
- You have provided patient details (if different to policyholder) in section (B)
- You have provided your registered dentist details in section (C)
- Your dentist has completed all relevant sections in section (D)
- Your dentist has signed, dated and stamped section (D)
- You have signed the declaration and authority in section (E)
- You have provided additional information on previous dentists (if required) in section (F)
- You have attached original itemised receipt(s)

Tick Box

IMPORTANT NOTICE:

- You must complete and submit the claim form within 30 days of the dental treatment, even if you are on a long term treatment plan. Failure to do so could result in your claim not being accepted.
- We will process claims forms within 10 working days.

PLEASE RETURN THIS CLAIM FORM TO:

Dencover Claims Department, Direct House, 4 Sidings Court, Doncaster, South Yorkshire DN4 5NU.

SHOULD YOU HAVE ANY PROBLEMS READING OR COMPLETING THIS FORM PLEASE CONTACT OUR CLAIMS DEPARTMENT ON:

0845 123 1078

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