Claim/application for authorisation to treat a dental injury worldwide

Supplementary Insurance/Denplan Emergency – Benefit B

Office use only. Claim reference number.

Link number.

INS02 / 02-14

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 that dental records may be required to support your claim.

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)

Patient Denplan 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 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 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 Denplan membership correspondence by email, please tick

Treating dentist's details

Dentist's Denplan membership 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 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? D D M M Y Y Y Y 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

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

If 'Yes' please give details

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

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

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

Please turn over

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

Please give details of treatment carried out so far

Please give details of the proposed plan for future dental treatment

What date did the treatment start? D D M M Y Y Y Y

When was the treatment completed? D D M M Y Y Y Y

Treatment code

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

	Quantity		
17		£	Examination and report to include all necessary smoothing, polishing and vitality testing
18		£	X-rays
19a		£	Porcelain jacket crown
19b		£	Dentine bonded crown
20a		£	Metal bonded porcelain crown
20b		£	Post/core construction
21a		£	Metal bonded porcelain bridgework – retainer
21b		£	Metal bonded porcelain bridgework – pontic
22		£	Full metal crown
23a		£	Zirconia crown
23b		£	Zirconia bridge unit
24a		£	Laboratory constructed adhesive bridge – retainer
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)

	Quantity		
26c		£	Root canal treatment – premolar (includes filling of access cavity)
26d		£	Root canal treatment – molar (includes filling of access cavity)
27a		£	Permanent acrylic denture
27b		£	Permanent metal denture
27c		£	Temporary denture following tooth loss (where required)
28a		£	Laboratory made temporary bridge following tooth loss (where required)
28b		£	Laboratory made temporary bridge following tooth loss (additional units)
29		£	Emergency and other treatment following dental injury not otherwise specified

Implants
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 by secure post.

34		£	Provision of an implant
35		£	Implant complimentary procedures (bone augmentation, CT scan)

Was it necessary to re-open your surgery? Yes ○ No ○ Date D D M M Y Y Y Y Time : AM ○ PM ○

Telephone consultation? Yes ○ No ○ Date D D M M Y Y Y Y Time : AM ○ PM ○

Payment details

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

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 credit to the account details held under the patient registration number

Or

○ Cheque payable to

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 D D M M Y Y Y Y

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 D D M M Y Y Y Y

Denplan Limited, Denplan Court, Victoria Road, Winchester, SO23 7RG, UK.
Tel: 0800 587 6578. Fax: 01962 849932. Email: trauma@denplan.co.uk

Denplan
At the heart of dental care