Claim for temporary emergency dental treatment in the UK with a dentist who is not acting on behalf of your dentist

Supplementary Insurance/Denplan Emergency – Benefit A

Office use only. Claim reference number.

INS01 / 05-16

Denplan Care, Denplan Essentials, Membership Plan and Plans for Children patients are not entitled to reimbursement for temporary emergency treatment when within 40 miles of their registered practice.

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 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 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)

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

If you are a patient claiming please provide as much information as possible

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

County 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.

Details of temporary emergency treatment (excludes permanent)

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

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

Was this arranged through the Denplan Emergency Helpline? Yes No

Helpline referral number (if you were provided with one)

What was the 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
Only complete if claiming payment for treatment

	Quantity	
1		Emergency examination/diagnosis and report to include all necessary smoothing, stoning and occlusal adjustments or fluoride varnish
2		X-rays
3		Extraction of up to two teeth
4a		Root canal extirpation to include dressings and/or temporary fillings and necessary prescriptions (incisors/canines)
4b		As 4a – two canals
4c		As 4a – three or more canals
5		Treatment of dental infection to include any necessary prescriptions
6a		Provision of temporary filling, first tooth
6b		Provision of temporary filling, additional teeth
6c		Provision of an incisor or canine composite filling
7		Recement crown or inlay
8		Recement bridge

	Quantity	
9		Construction and fitting of temporary crown
10a		Construction and fitting of temporary bridge/denture
10b		Provision of temporary post and core
11		Arrest of abnormal haemorrhage including aftercare and associated suture removal
12		Removal of sutures placed by another practitioner
13		Repair/adjustment of orthodontic appliance
14		Adjustment to denture
15		Repair of denture to include re-fixing of teeth and gums and repair of clasp
16		Any other temporary treatment, please specify below (including fee)

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

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 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)
If you are a dentist claiming a telephone consultation this section 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 X

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 by patient) X

Date D D M M Y Y Y Y

Denplan Limited, Denplan Court, Victoria Road, Winchester, SO23 7RG, UK.
Tel: 0800 0850 960. Fax: 01962 849932.

Denplan
At the heart of dental care