Dental Treatment Claim Form

This form allows us to:

1 review your claim and request a medical report or discuss your treatment with your medical practitioner, dentist or hospital if we need further information about your claim; and
2 carry out checks or audits to ensure the information that has been sent to us is correct.

Please complete the form in block capitals.

Patient's details (To be completed by the patient)

Policy/Customer Number

First name

Surname

Date of birth

d d m m y y y y

Address

Telephone number

Email address

1 Payment details (To be completed by the patient)

We normally settle eligible bills direct with the hospital and medical practitioner concerned. If you have paid the accounts, then we will require receipts and you will need to complete your payment details in the section below so we can reimburse you direct.

1.1 Currency for claim to be paid in

1.2 Bank account number

1.3 Bank name and postal address

1.4 Country

1.5 IBAN*

1.6 Swift code*

1.7 Account name

1.8 ABA number

*Note: the IBAN and Swift codes are required if payment is to be made in Euros

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Dental claim details

2 - Additional information (To be completed by the patient)

Description of Expense	Amount charged (please specify the currency)	Date of Treatment (dd/mm/yyyy)
Routine examination, including check-up and x-rays		
Cleaning and polishing (whether performed by a dentist or hygienist)		
Fillings (amalgam or composite material)		
Extractions		
Wisdom tooth extraction when performed in a dental surgery		
New porcelain crown or porcelain inlay		
Repair of crown/inlay		
Root canal treatment		
New bridge		
Repair of bridge		
New dentures		
Emergency dental treatment for the relief of pain, being treatment of an abscess, cracked or broken tooth rebuild or temporary filling.		
Accidental Damage caused to sound, natural teeth lost or damaged in an accident. Treatment must be received within 5 days from the date of the accident occurring.		
Dental surgery undertaken in a hospital by an oral maxillofacial surgeon or surgical dentist for removal of impacted or buried wisdom teeth and extractions of complicated, buried roots.		
Apicectomy performed in a hospital by an Oral Maxillofacial Surgeon or Surgical Dentist.		

3 - Declaration and consent (To be completed by the patient)

AXA PPP International are the underwriters and claims administrators for this policy.

I confirm I have read the information in this form. I wish to make a claim and declare that all the information I have given you is, to the best of my knowledge, true and correct.

- I consent to AXA PPP International reviewing the information on this form.
- I consent to AXA PPP International requesting medical information, if needed, from the patient's medical practitioner and/or hospital.
- I consent to the medical practitioner and/or hospital providing medical reports and access to copies of such health records as may be requested by AXA PPP International. This is so that AXA PPP International can:
  - a deal with the application/claim for benefit;
  - b undertake audits and other investigations; and
  - c process and share medical information with third parties where there is a legal requirement to do so.
- I consent to AXA PPP International reviewing the information in any medical reports or health records that may be requested.
- I consent to the medical practitioner, and/or hospital involved in the patient's care reviewing medical or treatment details and discharge arrangements with AXA PPP International.

I agree that AXA PPP International will send all further correspondence about this claim to the policyholder, unless I ask you not to.

3.1 **I declare** that I am the patient Yes ☐ No ☐

3.2 **Is the patient under 16** years of age? Yes ☐ No ☐

3.3 **If yes, I declare** that I am the patient's parent/guardian Yes ☐ No ☐

3.4 **I wish** to see any report from the medical practitioner before it is sent to you. Yes ☐ No ☐

3.5 Signed*

Date

d d m m y y y y

3.6 Patient's full name

(*To be signed by the patient or parent/guardian if the patient is under 16)

Checklist (Tick the appropriate boxes in this section)

- ☐ 1 **Completed the patient's details**
- ☐ 2 **Completed the payment details** (Section 1)
- ☐ 3 **Additional information details** (Section 2)
- ☐ 4 **Completed the declaration and consent** (Section 3.1-3.4)
- ☐ 5 **Signed and dated the form** (Section 3.5-3.6)
- ☐ 6 **Completed the Dental Certificate** (Section 4)

Patient's details

Patient's name

Policyholder's name

Patient's date of birth

d d m m y y y y

Policy/Customer number

4 – Dental Certificate - To be completed by the Dental Practitioner

Please complete the Dental Chart by using the guide below. (Alternatively please provide your treatment plan and dental chart).

Dental Chart

	Right								Left								
Treatment																	Treatment
Upper	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Jaw
Lower	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Jaw
Treatment																	Treatment

Guide

Treatment	Code	Treatment	Code
Accidental Damage	AD	Repair of Crown/Inlay	RC
Apicectomy	AP	Repair of Bridge	RB
New Bridge	B	Root Canal Treatment	RCT
New Dentures	D	Surgery	S
Extractions	E	Wisdom Tooth Extraction	EX
Fillings (amalgam/composite)	F	Other, including emergency treatment of an abscess, cracked or broken tooth rebuild, temporary filling or x-ray. (Please give details below)	O
New Porcelain Crown or porcelain inlay	NC		

Date of examination (dd/mm/yyyy)

Routine Examination ☐ Date (dd/mm/yyyy)

Cleaning ☐ Date (dd/mm/yyyy)

Does the patient require further treatment? Yes ☐ No ☐

If Yes, when is the proposed date? (dd/mm/yyyy)

Has the patient been referred to Oral Maxillofacial Surgeon or other? Yes ☐ No ☐

If Yes, please provide name and full contact details

Please provide full details of the condition requiring treatment/surgery

Please provide full details of the proposed treatment/surgery

Name of examining Dentist/Oral Maxillofacial Surgeon/Surgical Dentist/Hygienist

Name

Qualifications

Address

Postcode

Telephone Number

Fax Number

Signature

Official Stamp

Date (dd/mm/yyyy)

5 Important information

Please read carefully and keep for your records (you do not need to return this page).

Access to Medical Reports Act 1988:

You need to understand these rights before you agree to us requesting a report from the medical practitioner treating you. These rights do not relate to reports from practitioners who are not responsible for treating you. Also, when we ask for information from your medical records such as a copy of your medical notes, only the first point applies.

- You can withhold your consent, but if you do so, we might not be able to process your claim.
- If we need a report we will write to you to tell you the date it was requested.
- You can indicate in the box in section 6 Declaration and consent 6.4 of this form if you would like to see any report from the medical practitioner before it is sent to us. You have 21 days from the date of our request to do this and it is up to you to contact the medical practitioner. If you change your mind before the report has been sent to us, you can contact your medical practitioner to see it. You have 21 days from the date of our request to do this.
- If you disagree with the information in the report, you can contact the medical practitioner to change it. If the medical practitioner does not agree with you, they will ask you to write a statement to be attached to the report that is sent to us.
- You can ask the medical practitioner to see the report at anytime within six months of the medical practitioner sending it to us.
- Your medical practitioner may charge you for a copy of the report. This charge is not covered by your scheme/policy.
- Your medical practitioner does not have to show you parts of the report if they think it could cause harm to your physical or mental health.
- If the report includes information about someone else, the medical practitioner will not show you that part of the report.
- If the medical practitioner does not want you to see part of their report, they will tell you in writing, but you can still view other parts of the report.

Data Protection Act 1998:

Information about health, medical history and any treatment that you have is sensitive personal information.

- We need your consent to process your sensitive personal information.
- You are entitled to receive information we hold about you. We may make a small charge for providing this.
- You can write to us to ask for a copy of any personal information contained in an independent report we have requested.
- If you would like a copy of a medical report that your medical practitioner has sent to us, you will need to contact them directly.
- Your claims may be processed in confidence on our behalf, outside the European Economic Area.
- We will send all claims correspondence to the policyholder unless you ask us not to.

Auditing and the prevention and detection of crime.

We may audit the records of medical practitioners and hospitals to:

- Ensure that we are being correctly billed for their services;
- Prevent and detect crime, particularly fraud; or
- Review the performance of specialists.

Audits may be part of a programme or in response to a specific circumstance and may involve reviewing customers' medical records held by the person or organisation being audited.

We may need to share information that we receive with third parties. This includes medical experts, other insurers, the NHS Counter Fraud Security Management Service and the General Medical Council. We are required by law, in certain circumstances, to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crimes.

This may involve adding non-medical information to a database that will be viewed by other insurers and law enforcement agencies. We are required to notify the General Medical Council or other relevant regulatory body about any issue where we have reason to believe a medical provider's fitness to practice may be impaired.

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TR 5132 26/10/11