DENTAL COVER

CLAIM FORM

FILLING IN THIS FORM

The patient should complete sections 1 and 2 of this form for all claims for dental treatment. Leaving fields blank or making marks may lead to delays if we have to return the form to you for more information. If the patient is under 16 years old, his or her legal guardian should complete it.

Section 3 should be completed by the patient's regular dental practitioner for all claims for dental treatment.

If the patient is claiming for a routine examination, x-ray or scale and polish, sections 2 and 3 do not need to be completed.

Once completed, please return this form to:

VitalityHealth, St Christopher House, Wellington Road South, Stockport, Cheshire, SK2 6NG.

Issuing this form is not an acceptance of your claim or confirmation that benefits will be available. Limits apply to eligible claims.

SECTION 1 - PATIENT'S DENTAL STATEMENT

YOUR DETAILS

Patient's name

Date of birth D D M M Y Y Y Y

Patient's address

Postcode

Membership number

Claim number

YOUR DENTAL PRACTITIONER'S DETAILS

If registration with your current dental practitioner is less than 12 months ago, please also give details of your previous dental practitioner.

Date registered with your current dental practitioner: D D M M Y Y Y Y

Current dental practitioner:

Name:

Address:

Postcode:

Previous dental practitioner:

Name:

Address:

Postcode:

Date of the last dental check up with your current dental practitioner: D D M M Y Y Y Y

Date of the last dental check up with your previous dental practitioner: D D M M Y Y Y Y

VitalityHealth

ABOUT YOUR CONDITION

Please give us details of the symptoms and the treatment you are claiming for:

Please be as accurate as possible when stating dates.

When did you first notice the symptoms? D D M M Y Y Y Y

Was this dental treatment required because of a dental accident? Yes ☐ No ☐

An emergency dental appointment must immediately follow the dental accident or the insured person must seek treatment through an Accident and Emergency (A&E) department.

Please state the circumstances including dates relating to the injury

Please also give us itemised receipts, when treatment is complete, for us to pay you direct. We cannot assess your claim without this information.

YOUR DECLARATION AND SIGNATURE

- I declare that to the best of my knowledge and belief, the information I have given in this form is true and complete.
- If I am claiming for dental treatment, I confirm I have been informed of my rights under the Access to Medical Reports Act 1988 as detailed in section 2.
- I accept that if VitalityHealth receives any information that would have changed its original decision to pay a benefit, I will immediately repay any money I have received.
- A copy of our data protection notice is included within your terms and conditions. These were provided when you took out the plan or are available on the Member Zone at member.vitality.co.uk. If you have any questions about this notice, please write to: VitalityHealth, Stirling, FK9 4UE.

If the patient is under 16 years of age, his or her legal guardian should sign on their behalf.

Patient's signature

Date D D M M Y Y Y Y

SECTION 2 - ACCESS TO MEDICAL INFORMATION

Before we can assess your claim for dental treatment, we may need to get a medical report from a dental practitioner who has cared for you. The Access to Medical Reports Act 1988 gives you certain legal rights. These are:

- We need your agreement before we can apply for a medical report. You can refuse, but if you do, we will not be able to assess your claim or provide you with any benefit.
- You can ask to see the report before it is sent to us, or for up to six months afterwards.
- If you tell your dental practitioner that you want to see the report, this may delay the assessment of your claim, and they can charge you a reasonable fee to cover costs.
- If you think part of the report is incorrect or misleading when you see it, you can ask to have it changed. If your dental practitioner will not agree to do this, you may attach a statement of your own.

You will not be entitled to see any part of the report which:

- the dental practitioner believes could seriously harm your physical or mental health, or that of others;
- indicates the dental practitioner's intentions in respect of you;
- reveals information about another person, or the identity of someone who has given information about you (unless that person consents or is a health professional involved in caring for you).

We will write and tell you when we have requested the report. If you've asked to see the report before your dental practitioner sends it to us, you will have 21 days from receipt of our letter to contact your dental practitioner. Once you have seen the report, your agreement is needed for it to be sent to us. If you don't arrange to see the report within 21 days, your dental practitioner will be free to send it to us.

YOUR CONSENT AND SIGNATURE

- I have been informed of my rights under the Access to Medical Reports Act 1988 as explained above. In connection with this claim, I give consent to VitalityHealth to be provided with medical information by any dental practitioner who has treated me.

Please tick if you **do** want to see the report before it is sent to us. ☐

- I agree that a copy of this consent is as valid as the original.

If the patient is under 16 years of age, his or her legal guardian should sign on their behalf.

Patient's signature

Date

D D M M Y Y Y Y

SECTION 3 - DENTAL PRACTITIONER'S STATEMENT

Please be as accurate as possible when stating dates.

The patient's regular dental practitioner should complete this section.

The patient is responsible for paying any fee.

Please give the date the patient first registered with your practice. D D M M Y Y Y Y

Please give the date you recommended the treatment stated below. D D M M Y Y Y Y

How long had the patient had these symptoms? D D M M Y Y Y Y

Please let us know your reasons for recommending this course of treatment.

Please give details of the item, or items, of present treatment for which the patient is claiming. Please state which tooth or teeth where appropriate.

Item	Tooth or teeth	Cost	Date of treatment
Routine examination		£	D D M M Y Y Y Y
Scale and polish		£	D D M M Y Y Y Y
X-ray		£	D D M M Y Y Y Y
Fillings		£	D D M M Y Y Y Y
Root canal treatment		£	D D M M Y Y Y Y
Extractions		£	D D M M Y Y Y Y
Crowns		£	D D M M Y Y Y Y
Bridgework		£	D D M M Y Y Y Y
Implants		£	D D M M Y Y Y Y
Inlay/onlay/overlay		£	D D M M Y Y Y Y
Apicectomy		£	D D M M Y Y Y Y
New/replacement dentures		£	D D M M Y Y Y Y

A requirement for claiming for emergency treatment is that the patient must have been treated in an emergency dental appointment for which evidence must be provided.

Emergency dental treatment		£	D D M M Y Y Y Y
Emergency call out fee			£

Was this dental treatment required because of a dental accident? Yes ☐ No ☐

An emergency dental appointment must immediately follow the dental accident or the insured person must seek treatment through an Accident and Emergency (A&E) department.

Date of accident D D M M Y Y Y Y

Date of emergency appointment with dental practitioner or A&E visit D D M M Y Y Y Y

Please state the circumstances of the accident and give us a fully itemised treatment plan

Please give the dates of the last two full dental check-ups before this course of treatment.

D D M M Y Y Y Y D D M M Y Y Y Y

Did you recommend any further treatment at these check-ups? Yes ☐ No ☐

If 'yes', did the patient complete all treatment? Yes ☐ No ☐

If 'no', what treatment is outstanding?

YOUR DENTAL PRACTITIONER'S DECLARATION

- I confirm I am the patient's dental practitioner.
- I consent to giving a copy of this dental statement to the patient. Yes ☐ No ☐
- I declare the information given on this form is true and complete.

Dental practitioner's signature

Practice stamp or address

Dental practitioner's name

Date D D M M Y Y Y Y

Discovery

Part of the Discovery Group