Claim for re-opening a dental practice for dental emergencies and dental injuries

Denplan
Part of Simplyhealth

Denplan Dental Emergency and Injury Cover/Denplan Emergency – Benefit C

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 0800 0850 960, or email DenplanClaimForms@simplyhealth.co.uk

Please send your completed form, within 60 days of the incident where reasonably possible, by email - DenplanClaimForms@simplyhealth.co.uk or by post - Denplan, part of Simplyhealth, Anton House, Chantry Street, Andover, SP10 1DE

Patient details

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

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/City Postcode

Home phone number Mobile phone number

Email address*

*If you enter an email address on this form and you're the payer, it will be added to your account and email will become your preferred contact method. If you're not the payer, we'll use the email to contact you about your claim. Providing an email helps us communicate faster, improves security, and reduces our environmental impact. Please contact us if you'd like to discuss this further

Treating dentist's details

If the dental practice are unavailable to complete this section, please add in as much information as you know

Registration facility number (e.g. 251403/a) / (Last character should be a letter)

Mr ○ Mrs ○ Dr ○ Miss ○ Ms ○ Other ○

First name Surname

Practice name

Practice address

Town/City Postcode

Practice email address

Practice phone number

Do you have a Denplan Contract with this patient? Yes ○ No ○
If 'No' are you connected* with the patient's Denplan member dentist? Yes ○ No ○ (*e.g. Partner, expense sharing colleague, associate, locum or part of the same rota)

Claim for emergency call-out

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 ○

If 'No' at what time did you contact the surgery? Time : AM ○ PM ○

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
Please tick relevant treatment code box(es)

If claiming a **call-out fee** tick one box below. Please note that only one fee can be claimed in this section.

Was it necessary to re-open your surgery? Yes ○ No ○

27 Opening the practice / emergency home visits ○

28 Telephone consultation (where no attendance follows) ○

Payment details

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

Please ensure that you complete this section fully.

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 payment into the bank account we debit your monthly subscription from

Or

○ Cheque payable to

Patient's declaration

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 Limited, or its representatives, with any information concerning the above matters to support this claim. I understand that Denplan Limited, 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

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)

Date D D M M Y Y Y Y