Claim/application for authorisation to treat a dental injury worldwide

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

Denplan
Part of Simplyhealth

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 have any questions, please email trauma@simplyhealth.co.uk

Please send your completed form, within 60 days of the incident where reasonably possible, by email - trauma@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 you are a patient claiming please provide as much information as possible

Registration facility 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/City

Postcode

Practice email address

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		
15		£	Examination and report to include all necessary smoothing, polishing and vitality testing and X-rays
16a		£	Porcelain jacket crown
16b		£	Dentine bonded crown
17a		£	Metal bonded porcelain crown
17b		£	Post/core construction
18a		£	Metal bonded porcelain bridgework – retainer
18b		£	Metal bonded porcelain bridgework – pontic
19		£	Full metal crown
20a		£	Zirconia crown
20b		£	Zirconia bridge unit
21a		£	Laboratory constructed adhesive bridge – retainer
21b		£	Laboratory constructed adhesive bridge – pontic
22		£	Laboratory constructed adhesive facing or veneer
23a		£	Root canal treatment – incisor and canine (includes filling of access cavity)
23b		£	Root canal treatment – premolar and molar (includes filling of access cavity)

	Quantity		
24a		£	Permanent acrylic denture
24b		£	Permanent metal denture
24c		£	Temporary denture following tooth loss (where required)
25		£	Laboratory made temporary bridge following tooth loss (where required). Also includes adding additional units
26		£	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.

31		£	Fitting an implant
32		£	Procedures to support fitting of the implant (bone augmentation, CT scan)

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

Telephone consultation? Yes ○ No ○

What was the date and time of the treatment/consultation? 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 payment into the bank account we debit your monthly subscription from

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 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

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