

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

## Denplan Dental Emergency and Injury Cover/Denplan Emergency – Benefit A

Denplan Care, Denplan Essentials, Denplan Hygiene, Denplan Membership and Denplan 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 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](mailto:DenplanClaimForms@simplyhealth.co.uk)

Please send your completed form, within 60 days of the incident where reasonably possible, by email - [DenplanClaimForms@simplyhealth.co.uk](mailto: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

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)

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)

### 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?        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?

Quantity		Quantity		
1		Emergency examination / diagnosis and report to include all necessary smoothing, stoning and occlusal adjustments or fluoride varnish and X-rays	11	Arrest of abnormal haemorrhage including aftercare and associated suture removal (including those placed by another practitioner)
2		Extraction of up to two teeth	12	Repair / adjustment of orthodontic appliance
3		Root canal extirpation to include dressings and/or temporary fillings and necessary prescriptions	13	Adjustment / repair to denture
4		Treatment of dental infection (including necessary prescriptions)	14	Any other temporary treatment, please specify below (including fee)
5		Provision of temporary filling		
6		Provision of an incisor or canine composite filling		
7		Recement crown or inlay		
8		Recement bridge		
9		Construction and fitting of temporary crown		
10a		Construction and fitting of temporary bridge/denture		
10b		Provision of temporary post and core		

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

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

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 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

/

## 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

/