Bolton & District
Hospital Saturday

Dental Claim Form

Sections **1**, **4, 5** and **8** should be completed by the policyholder
Sections **2** and **3** should be completed by the dentist

1. Policyholder Details

Policyholder's name

Policy number | Telephone number

Address | Postcode

Email Address

Date of birth

2. Treatment Received (to be completed by dentist)

Practice Name | Telephone number

Brief description of treatment undertaken

Date of treatment | Cost of treatment £

Type of treatment (NHS/Private/Emergency)

Date the patient was first made aware of this treatment

Dates of last two previous examinations

Was all recommended treatment for these visits completed? Yes ☐ No ☐

Dental Treatment Breakdown

Examination	Date		Date patient informed treatment required	N/A	Cost	
Scale and Polish	Date		Date patient informed treatment required		Cost	
X-rays	Date		Date patient informed treatment required		Cost	
Fillings and root canal	Date		Date patient informed treatment required		Cost	
Which tooth/teeth?			Were any fillings white?	Yes ☐	No ☐	
Crowns / Bridges	Date		Date patient informed treatment required		Cost	
Construction used						
Dentures / Repairs	Date		Date patient informed treatment required		Cost	
Prescriptions	Date		Date patient informed treatment required		Cost	
Total Cost						

3. Dentist's Declaration (to be completed by dentist)

- I confirm that the treatment detailed on the invoice provided has been paid in full to the sum of £
- I confirm that the patient has been examined during the twelve months prior to the date of joining this scheme and all necessary remedial treatment was completed at that time.
- I confirm that the treatment was not planned prior to the enrolment date.
- I confirm that the above details are true and correct and that all treatment is now completed. I also confirm that the treatment was necessary to secure and maintain oral health.

Practice stamp

Signature

4. Accident/Emergency (to be completed by policyholder if applicable)

Date of accident

Date of treatment

How did the incident occur and what symptoms did you suffer?

Type of treatment resulting from the accident

Did the accident involve someone else you may be claiming against? Yes No

5. Payments

If you wish your payment to be paid directly into the bank then please enter your own account details:

Account Name

Sort Code – –

Account N°

Once you have chosen this method we will pay all future claims into your nominated bank account.
As a consequence it will no longer be necessary to send you separate written notification of payment.

6. Data Protection Act 1998

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

- Usually we need your consent to process your personal information.
- You have a right to receive details of the information we hold about you. We may make a small charge. We may ask for dental information via your dentist.
- If on reading a dental record you believe it is inaccurate or misleading you can request that an amendment is attached to it.
- You may request from us, in writing, a copy of any personal information contained in any independent report that we obtain.
- You should contact your own dentist for any report they produce.
- We send claims correspondence to the policyholder unless we are advised to do otherwise.

7. Prevention & Detection of Crime

Please note that your insurance policy with us is based on mutual trust. If we are suspicious that any claim may be fraudulent we have rigorous anti-fraud measures in place. These may include auditing the records of medical practitioners to prove that our customers are correctly billed for the services received effectively to prevent and detect crime. This may also involve auditing the policyholder's medical and health records before or after treatment. We may need to share information received with third parties such as the General Medical Council or the NHS Counter-Fraud Security Management Service as we deem appropriate. We may also be required by law to submit information to law enforcement agencies about our suspicions of fraudulent claims and other crime.

8. Policyholder Declaration

I confirm that the information provided is to the best of my knowledge true and correct. In order that my claim may be settled I agree to Bolton & District Hospital Saturday Council processing the particulars in this form or in any medical reports or records that may be required.

Signature

Date

Full name

Checklist!

- Have you signed the form?
- Has your dentist signed the declaration and provided their stamp?
- Is this claim within 3 months of the date of treatment?
- Are appropriate receipts (plus debit and credit card receipts) attached?
- Have you included an itemised treatment bill from your dentist?

Please return this form to:

Bolton & District Hospital Saturday Council, Ground Floor, Regent House, Folds Point, Folds Road, Bolton BL1 2RZ

For office use only

Date PUTD

Type	Credit/Chq	Auth	Ref	Amount