Supplementary worldwide dental accident and emergency

Claim form for Dental Treatment following an Accident

This claim form should be completed to claim under section 2 (Dental treatment following an accident) of the policy. If your claim falls under another section of the worldwide dental accident and emergency cover, please complete the specific claim form accordingly, available from your registered dental practice.

How to complete and submit your claim form

Please complete all sections and write clearly in BLOCK CAPITALS using black or blue ink.

You must have sought treatment following an accident within 7 days of the incident. This form, countersigned by the treating dentist must be sent to the Insurance team at PPD within 30 days of the accident (60 days if the incident occurs overseas). Costs will be reimbursed up to the limits shown in the policy. Any amount which exceeds the specified limit must be paid directly by you to the treating dentist. You must provide all necessary reports, receipts, and other documentation in support of the claim when asked to do so.

Reference to the policy wording will assist you in completing this form. If you have any questions regarding making a claim please contact your dental practice or call the claims help line on 01482 213 215

Please return scans of completed claim forms by email to: ppd@jelf.com

Alternatively, please post hard copies to: Patient Plan Direct Claims Partnership House Priory Park East Hull HU4 7DY

IMPORTANT – Please note that you may not claim more than £250 in total unless we have previously approved a treatment plan.

If you are submitting a treatment plan before any treatment commences to obtain pre-authorisation please tick here ☐

Patient Details

Full name	
Date of Birth	
Address	
Postcode	
Telephone number(s)	/
Email Address	
Plan reference number *(available from your registered practice)*	

Your Registered Practice Details

Full name	
Practice	
Practice Address	
Postcode	
Telephone number	
Email Address	

Treating Dentists Details (if different to registered practice details, otherwise leave blank)

Dentist name	
Practice	
Practice Address	
Postcode	
Telephone number	
Email Address	

Accident Details

Date & Time of accident	
Where did the accident happen	
Please provide details of how the accident occurred and any injury incurred	
Was a call out fee charged?	
Was a telephone consultation provided?	

Please provide details of any treatment completed so far (please detail costs for each treatment item)

(please submit invoice for this treatment)

Treatment	Tick	Cost (£)
Examination and report to include necessary smoothing and polishing		
X-ray examination		
Root canal treatment − incisor or canine root canal treatment		
Root canal treatment − premolar		
Root canal treatment − molar		
Crowns - post and core construction		
Crowns − ceramic bonded (including any core and/or post interim covering)		
Crowns − metal bonded porcelain (including any core and/or post including interim covering)		
Crowns – full metal (including any core and/or post including interim covering)		
Bridges − all metal (Retainer)		
Bridges − all metal (Pontic)		
Bridges − bonded metal/porcelain (Retainer)		
Bridges − bonded metal/porcelain (Pontic)		
Laboratory made temporary bridge following tooth loss		
Laboratory made temporary bridge following tooth loss		
Laboratory constructed adhesive facing or veneer		
Dentures − permanent acrylic		
Dentures − permanent metal		
Dentures − temporary following tooth loss		
Other necessary dental treatment (please detail below)		

Date treatment started and finished / finishes

Start: Finish:

Please provide details of any on-going / further treatment that is required

(Please submit a detailed treatment plan indicating expected costs for any treatment items. If more space is required, please complete on a separate sheet attached with claim form)

Payment Details

IMPORTANT – Please note, irrespective of which party we are due to pay, we will require a copy invoice detailing any treatment as a result of the accident.

Payment should be made to:

☐ **Patient** *(Payment will be transferred to your bank account from where regular plan fees are collected)*

☐ **Your Registered Practice** *(Payment will be transferred to the practice bank account PPD have on record)*

☐ **Treating Dentist at another Practice** *(A cheque will be sent to the practice)*
Please indicate the name of the business which the cheque should be made payable to:

Using your personal information

We collect and process information about you in order to provide insurance policies and to process claims. Your information is also used for business purposes such as fraud prevention and detection and financial management. This may involve sharing your information with, and obtaining information about you from, our group companies and third parties such as brokers, loss adjusters, credit reference agencies, service providers, professional advisors, our regulators or fraud prevention agencies. For further information on how your information is used and your rights in relation to your information please request to review a copy of our privacy policy.

Patient Declaration

I declare that (a) this form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of the claim have been disclosed.

Name **Signature** **Date**

Dentist Declaration

I declare that (a) this form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of the claim have been disclosed.

Name **Signature** **Date**