Dental Treatment Claim Form

The following notes have been prepared to assist you with your claim. Please read them carefully **BEFORE** you complete this form. Please note that we are not responsible for any fees that you may incur for completion of this form. The issue of this claim form is in no way representative of an admission of liability. For ongoing claims please complete a Continuation of Claim Form.

Are you covered? Where to send the claim form

It is important to check your policy to make sure that you are covered for the expenses for which you are claiming. If you are in any doubt as to what your policy covers, please feel free to contact our Helpline staff on:

T + 353 1 629 7140

Calls may be recorded or monitored for quality and training purposes.

F + 353 1 630 1306

E claims@alchealth.com

All claims correspondence should be sent to:

à la carte healthcare claims
Allianz Worldwide Care Ltd
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

Direct payment of in-patient/day-patient medical bills for dental surgery

You are requested to contact us at least **FIVE DAYS** prior to planned hospital admissions so that we can communicate with the hospital to facilitate smooth admission and guarantee direct payment. **Please note that without sufficient notice and the necessary medical information, we cannot guarantee that we will be able to arrange direct payment.**

Completing the form

- A **fully completed form** will allow us to make an efficient assessment and prompt payment of your claim.
- Please complete Sections A, B, and C and ask your Dental Practitioner to complete and sign Section D – the Dental Certificate. If Section D is not completed or signed, the claim cannot be processed.
- **Please attach all original invoices confirming the cost of each treatment.** Photocopies, receipts and credit card slips cannot be accepted.
- A separate Claim Form is required for each patient.
- We recommend that you keep copies of all documents submitted, should you require them at a later date.
- All documents and materials (including but not limited to original accounts, certificates and x-rays) that we require to support a claim shall be provided without expense to us.
- Any fee for completion of Section D is the responsibility of the Policyholder/Claimant.
- If your Claim Form has been altered in any way, your claim may be rejected.

Allianz Worldwide Care Limited underwrite the risk and administer claims on behalf of à la carte healthcare limited.

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GLOBAL HEALTH INSURANCE

Dental claim details

Section A - Policyholder & claimant details

Name of Policyholder (as shown on the Certificate of Insurance)

Policy Number

Name of Group (if applicable)

Name of claimant

Correspondence Address

Postcode

Country

Date of birth (dd/mm/yyyy)

Gender Male Female

Telephone Number

Fax Number

Email Address

Section B - Amount claimed (continue on a separate sheet if necessary)

Description of Expense	Amount charged (please specify the currency)	Date of Treatment (dd/mm/yyyy)
Routine examination, including check-up and x-rays		
Cleaning and polishing (whether performed by a dentist or hygienist)		
Fillings (amalgam or composite material)		
Extractions		
Wisdom tooth extraction when performed in a dental surgery		
New porcelain crown or porcelain inlay		
Repair of crown/inlay		
Root canal treatment		
New bridge		
Repair of bridge		
New dentures		
Emergency dental treatment for the relief of pain, being treatment of an abscess, cracked or broken tooth rebuild or temporary filling.		
Accidental Damage caused to sound, natural teeth lost or damaged in an accident. Treatment must be received within 5 days from the date of the accident occurring.		
Dental surgery undertaken in a hospital by an oral maxillofacial surgeon or surgical dentist for removal of impacted or buried wisdom teeth and extractions of complicated, buried roots.		
Apicectomy performed in a hospital by an Oral Maxillofacial Surgeon or Surgical Dentist.		

Please note the following:
Where a currency conversion is required the rate will be that prevailing at the date of the invoice

Payment Details:

Payment to Policyholder ☐ Payment to Insured ☐ Payment to Provider ☐

Payment to be made in: Invoice currency ☐ Other currency (Please specify)

Preferred payment method: Cheque ☐ Bank transfer (Please fill in bank details below)

Name of bank account			
Account no./IBAN		Sort/branch code	
Swift code		Bank name	
Bank address			
		Postcode	

Section C – Declaration

I declare that to the best of my knowledge all particulars contained in this form are true. I hereby give my permission for any Dental Practitioner or other authority mentioned herein to release further information regarding my Dental records to à la carte healthcare limited and their appointed administrators. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Reports Act (AMRA) or other similar legislation. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution.

Data Protection Act

The Insurance Industry operates a number of anti fraud initiatives. The information on this form may be stored electronically and we may release certain information to other insurers or other interested parties. All data is maintained in accordance with the provisions of the Data Protection Act.

Signed (Policyholder/Claimant)

Date (dd/mm/yyyy)

(If patient is under 18 years, parent or guardian must sign)

Section D – Dental Certificate - To be completed by the Dental Practitioner

Please complete the Dental Chart by using the guide below. (Alternatively please provide your treatment plan and dental chart).

Dental Chart

	Right								Left								
Treatment																	Treatment
Upper	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Jaw
Lower	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Jaw
Treatment																	Treatment

Guide

Treatment	Code	Treatment	Code
Accidental Damage	AD	Repair of Crown/Inlay	RC
Apicectomy	AP	Repair of Bridge	RB
New Bridge	B	Root Canal Treatment	RCT
New Dentures	D	Surgery	S
Extractions	E	Wisdom Tooth Extraction	EX
Fillings (amalgam/composite)	F	Other, including emergency treatment of an abscess, cracked or broken tooth rebuild, temporary filling or x-ray. (Please give details below)	O
New Porcelain Crown or porcelain inlay	NC		

Date of examination (dd/mm/yyyy)

Routine Examination ☐ Date (dd/mm/yyyy)

Cleaning ☐ Date (dd/mm/yyyy)

Does the patient require further treatment? Yes ☐ No ☐

If Yes, when is the proposed date? (dd/mm/yyyy)

Has the patient been referred to Oral Maxillofacial Surgeon or other? Yes ☐ No ☐

If Yes, please provide name and full contact details

Please provide full details of the condition requiring treatment/surgery

Please provide full details of the proposed treatment/surgery

Name of examining Dentist/Oral Maxillofacial Surgeon/Surgical Dentist/Hygienist

Name Qualifications

Address

Postcode

Telephone Number Fax Number

Signature Official Stamp

Date (dd/mm/yyyy)

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