

Emergency Treatment Claim Form



Policy No. **RTT5645**
Claim No.
Insurance Monthly Insurance Annually
Plan Type Full Care
Maintenance
Children's

Emergency only
Dental injury
Hospital benefit

PATIENT DETAILS

Title Surname

Forename(s)

Address

Date of Birth

Registration No. (if known)

DETAILS OF PATIENT'S REGULAR DENTIST

(to be completed by administration)

Dentist Name

Plan No.

TO BE COMPLETED BY TREATING DENTIST

Name of Dentist

Practice Stamp

Address

Date of Treatment

I have carried out the treatment as detailed overleaf and claim payment of the fees due to me (if any)
(Please attach a detailed account of treatment)

Dentist's Signature

Date

Total cost
£ :

Patient contribution
£ :

Total claimed
£ :

Pay Patient

Pay Dentist

Or Cheque Payable to (BLOCK CAPITALS ONLY)

OUT OF HOURS TREATMENT

Emergency treatment took place 'out of hours' on (Date and Time)

Day Date at am/pm

The Insured Patient shall be responsible for the first £15.00 of each and every claim under item (n), (p) i) and ii) and (q).

HOSPITAL BENEFIT

Please give dates of hospitalisation

From	/	/	am/pm	to	/	/	am/pm
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Name and address of Hospital

Please enclose a hospital discharge form

SECTION 1 - EMERGENCY TREATMENT

To be completed by the treating Dentist. If the treating Dentist is the patient's contracted Dentist or is deputising for the patient's contracted Dentist only items (p) or (q) should be completed. (Please complete amount claimed in appropriate box.) **£**

- | | |
|---|--|
| (a) Examination and report to include all necessary smoothing and polishing of teeth and treatment of sensitivity | |
| (b) Radiographic examination | |
| (c) Extraction of up to 2 teeth | |
| (d) Root extirpation to include dressing and any associated treatment of acute infection | |
| 1 canal | |
| 2 canals | |
| 3 or more canals | |
| (e) Treatment of acute infection (not associated with endodontic therapy) to include incising of abscesses and treatment of infected sockets | |
| (f) (i) investigation and dressing-first tooth | |
| (ii) each additional tooth | |
| (g) Recement crown or inlay | |
| (h) Recement bridge | |
| (i) Construction and fitting of temporary crown | |
| (j) (i) Construction and fitting of temporary bridge | |
| (ii) Provision of temporary post and core (per tooth) | |
| (iii) Temporary Denture following tooth loss | |
| (k) Arrest abnormal haemorrhage including aftercare and associated suture removal | |
| (l) (i) Removal of sutures placed by another practitioner | |
| (ii) Repair/Adjustment of orthodontic appliances | |
| (m) Adjustment to denture | |
| (n) Repair of denture to include refixing of teeth and gum, and repair of clasp | |
| (o) Any other Emergency Treatment not otherwise specified | |
| (p) (i) Evening, weekend and Bank Holiday call out fees (other than those mentioned at (ii) below) where the Dentist returns to the practice to re-open it to provide emergency treatment when the surgery would not normally be open | |
| (ii) From 6.00pm on 24th December until 12.01am on 27th December and again from 6.00pm on 31st December until 12.01am on 3rd January any call-out fees where the Dentist returns to the practice to re-open it to provide emergency treatment when the surgery would not normally be open | |
| (q) Telephone consultation when attendance not required | |

Description of Treatment

DATA PROTECTION ACT

All personal information supplied by you will be treated in confidence by Hart Insurance Brokers and the RSA Group of companies and will not be disclosed to any third parties except where your consent has been received or where permitted by law. In order to provide you with products and services this information will be held in data systems of Hart Insurance Brokers and the RSA Group of companies or our agents or subcontractors.

DECLARATION

I confirm I am registered with Highland Dental Plan Ltd. I understand the Treatment as detailed above has been carried out and claim repayment of fees paid by me (if any).

I declare that the above statements are true and correct to the best of my knowledge and belief. I have not withheld from RSA any information within my knowledge connected with this claim.

I accept that if I exaggerate any part of this claim or make any false declaration or statement, I shall not be entitled to receive any benefit under the policy in respect of this claim. Furthermore I accept that any such action on my part may render me liable to prosecution.

I agree to provide RSA with any further information or documentation as may be reasonably required.
I understand that RSA does not admit liability by the issue of this form.

I understand that you may seek information from other insurers to check the answers I have provided.

Signature of Dentist

Date

Signature of Patient

Date

**Patients claiming for Emergency Treatment should ensure that all original receipts are enclosed
(copies will not be accepted)**

Completed form to be returned to:

**Highland Dental Plan Ltd
River House
Young Street
Inverness IV3 5BL.**

Telephone (01463) 712585



Royal & Sun Alliance Insurance plc (No. 93792).
Registered in England and Wales at St Mark's Court,
Chart Way, Horsham, West Sussex, RH12 1XL.
Authorised and regulated by the Financial Services Authority.

UKC00685H

Highland Dental Plan Ltd (No. 307358).
River House, Young Street, Inverness IV3 5BL.
Authorised and regulated by the Financial Services Authority.

Hart Insurance Brokers (No 118751)
Erskine House, Clydebank Business Park,
Clydebank, Dunbartonshire G81 2DR.
Authorised and regulated by the Financial Services Authority.

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