Dental Plan Claim Form

How to fill out this claim form:

1. Complete all the fields (incl. Dentist details) on the form and ensure you sign the declaration.
2. Submit the form within 6 months of completion of the treatment you are claiming for.
3. Attach the documentation requested in the form.
4. Send your completed claim form to: **EduHealth Dental Plan, PO Box 6833, Basingstoke, RG24 4PR**
5. If you have any questions please contact the Claims Helpline on 0800 633 5037 or email: eduhealth@denisuk.com

To avoid delays in claim payments, these will be paid into the same bank account from where the insurance premium is collected by direct debit.

CLAIMANT DETAILS	
Full name of claimant:	Policy Number:
Address:	Telephone No.:
Postcode:	Email:

CLAIM DETAILS – Please select the type of claim and attach the requested documents

✓	Treatment Description	Tooth Notation	Treatment Date	Dentist charge £	Additional required documents
	2010 Dental Examinations	N/A	/ /	£	Detailed invoice from your dentist Original payment receipt(s) **Important note:** If it is the first visit to the dentist since joining the plan you must also attach evidence of the last time you went for a check-up.
	2020 Dental X-Rays	N/A	/ /	£	
	2030 Scale & Polish	N/A	/ /	£	
	2053 Dental Fillings		/ /	£	
	2060 Root Canal Treatment		/ /	£	
	2069 Extractions		/ /	£	
	2122 Anaesthetic Fee	N/A	/ /	£	
	2091 Crowns		/ /	£	
	2097 Bridges		/ /	£	
	2110 Dentures	N/A	/ /	£	
	2086 Veneers		/ /	£	
	2135 Implants		/ /	£	
	2121 Mouthguard	N/A	/ /	£	
	2130 Orthodontic Treatment	N/A	/ /	£	
	2002 Dental Injury Treatment	N/A	/ /	£	Accident report and original payment receipt(s)
	2004 International Dental Emergency	N/A	/ /	£	Payment receipt(s) translated to English if required
	2150 Hospital Cash Benefit	N/A	/ /	£	Medical report or letter from consultant detailing history of condition. Hospital discharge report (for any oral-related stay in hospital)
	2140 Oral Cancer	N/A	/ /	£	

NHS

	NHS BAND 1	£		NHS BAND 2	£		NHS BAND 3	£

DENTISTS DETAILS	
Dentist Name:	GDC No.:

DECLARATION & SIGNATURE

- I confirm that none of the treatment carried out in the attached invoice had been identified or planned prior to policy inception.
- I confirm I have had a routine dental check-up in the 24 months prior to policy inception.
- I declare that to the best of my knowledge and belief all the information given on this form is complete, true and correct.
- I agree to give my consent that any details regarding my claim may be discussed with my dentist.
- I confirm that I have received the treatment specified and have paid the stated fees and will not be seeking to claim the costs from any other party, including the government.

Signature of claimant:	Date: