May 2018

Vhi Dental Claim Form

INSTRUCTIONS FOR SUBMITTING CLAIMS – PLEASE READ CAREFULLY

Please ensure that **ALL** sections of this claim form are completed in **BLOCK CAPITALS**.

A new claim form must be completed for each insured person. You should complete and sign **SECTION A**. Your dentist or an authorised member of the dental practice should complete and sign **SECTIONS B** and **C** as appropriate.

Please note that under the PRSI dental scheme you may be entitled to a FREE annual examination in Ireland, this will not affect your claims limits, please check with your dentist if you are eligible before completing the claim form.

Benefits are remitted according to your table of benefits. This can be downloaded at **www.vhi.ie/downloads**

OVERSEAS COVER

If you require treatment whilst abroad, please obtain a detailed receipt in english and submit this with your claim form. Reimbursements will be related to your selected level of cover and the individual benefits listed. Settlements will be made in euro.

***Please note**: we are only able to accept receipts that have been translated into english, so you must arrange for this to be done before submitting them to us. You are responsible for the cost of any translation.*

ACCIDENT OR SPORTS INJURY

If you need dental treatment following an accident or a sports injury, you must inform the claims administrator within 7 days of the accident or as soon as reasonably possible. Please provide full details of the circumstances regarding the accident or injury

HOW TO MAKE A CLAIM

1. Complete **SECTION A** of this form and **bring it with you when you go to the dentist**
2. Once the treatment has been carried out, please get your dentist or an authorised member of the practice to complete **SECTION B** and **C** of this form. Please ensure **SECTION B** and **C** are fully itemised showing all treatments received and signed as appropriate
3. Settle the bill with your dentist and get a receipt
4. Send the fully completed claim form (1 form per patient) – together with the original payment receipts to Vhi Dental Claims
5. Your claim will be paid into your bank account within 10 working days

Please ensure that completed claim forms **reach us within 180 days of completion of each item of treatment**.
Please note that benefits will ***NOT*** be paid in respect of claims which arrive beyond this period.
Note: If your dentist is in the **Vhi Dental Network**, you can avail of **Dentist Direct Pay**. You still need to complete **SECTION A** of this Claim form. You will only need to pay the dentist for any costs not covered by your policy. Your dentist will submit the claim and will be reimbursed directly by us. If you wish to avail of Dentist Direct Pay you must phone Vhi Dental before you attend the dentist. For more details visit www.vhi.ie/dental

IMPORTANT

Your policy number must be included, the tooth numbers must be entered where applicable and the dentist must be identified by his/her IDC/GDC number on the claim form

If you have questions about your claim, call our **DENTAL CLAIMS HELPLINE** on **046 9077 337** from 8:30am - 6pm, Monday to Friday, 9am - 2pm, Saturday. Our experienced staff will be happy to help.

CLAIM CHECK LIST

Please ensure you have:

- Filled in and signed section A ☐
- Entered your bank details ☐
- Your dentist has filled in section B with relevant costs ☐
- Attached all receipts ☐
- Section C is complete with dentist IDC/GDC number ☐
- The dentist has stamped and signed the form ☐

CLAIMS ADMINISTRATOR
Vhi Dental Claims, Intana,
Collinson Insurance Services Limited,
IDA Business Park, Navan, Co. Meath
Phone: 046 90 77337
email: vhidentalclaims@intana-assist.com

SECTION A INSURED DETAILS: TO BE FILLED IN BY MEMBER

Name of policyholder			
Name of member			
Policy number		Member date of birth	
Payment to	Dentist ☐ If dentist, bank details are not required on this form Member ☐ If member, please enter bank details below		
Total claimed	€		
IBAN			
BIC			
Member address			
Email		Do you wish to receive settlement details by email?	Yes ☐ No ☐
Contact numbers	Home	Mobile	
Was this treatment received as a result of an emergency abroad or following an accident? If yes, please provide full details on a separate sheet.			Yes ☐ No ☐
Does the claimant hold dental insurance or any form of dental or medical insurance with any other provider? If yes, please provide details below:			
Provider:		Policy number:	

DATA PROTECTION STATEMENT

In order to adjudicate on your claim, Vhi and Intana will process the personal data you have provided on this form, together with any personal data that you have authorised third parties to provide to us. Certain processing of your personal data is required in order for us adjudicate on your claim and for us to be able to operate the business of providing dental insurance policies.

Vhi Healthcare DAC of Vhi House, Lower Abbey Street, Dublin 1 ("Vhi"), and Collinson Insurance Services Limited trading as Intana, of IDA Business Park, Athlumney, Navan, County Meath ("Intana"), and Great Lakes Insurance, SE of Plantation Place, 30 Fenchurch Street, London, EC3M 3AJ ("the Insurer"), are the companies that control and are responsible for processing the personal data in relation to your claim. We will process your personal data in accordance with the Vhi Data Protection Statement which has previously been provided to you. If you would like another copy of the Vhi Data Protection Statement it is available at Vhi.ie, or you can request a copy by calling us on **(056) 444 4444** *or* **1890 44 44 44.**

OBTAINING ADDITIONAL INFORMATION:

In order to process and to establish the eligibility and appropriateness of your claim we will, **as appropriate**;

- Contact the facility and your treating practitioners (including, where relevant, your GP) on your behalf to request a copy of all necessary information including, if requested, copies of the facility/medical records relating to the treatment and/or services received by you as part of this claim.
- Approach any third party who holds information relating to the incident giving rise to this claim and obtain from them such information as is required to assist in the investigation and resolution of this claim.
- Share information with other insurers or financial institutions for the purposes of dealing with this claim and eliminating insurance fraud.

Where it is necessary, we will ask you to allow the treating practitioners to share your information with us.

DECLARATION:

I declare that the information completed above at the time of signing this declaration is true in every respect.
I authorise Intana on behalf of the Insurer to pay the appropriate benefits, for services provided, to the treatment facility and medical practitioners concerned. I understand that the details of these amounts will be included in my settlement statement and I will contact Intana directly with any queries. Charges which are not eligible for benefit will remain my responsibility to settle directly with the treatment facility/medical practitioner concerned.

IMPORTANT – YOU MUST SIGN HERE:

Patient's (or Parent/Legal Guardian if patient is under 18 years)* Signature		Date	

**For claims in relation to a dependant under 18 years at the time of signing this form, please note that all correspondence and relevant payments will be made to the policyholder.*

Please check that you have entered your Policy Number.
Please note that the address you provide is purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Services Helpline at (056) 444 4444 or 1890 44 44 44.

CHECK LIST:

If all requested information is not supplied we will not be able to process your claim.

Before submitting your claim please ensure:

- All relevant documentation outlined on page 1 has been submitted with this claim.
- All supporting documentation are originals (we recommend that you retain copies).
- This claim form has been fully completed and signed.

SECTION B CLAIM DETAILS: TO BE FILLED IN BY A DENTIST OR AUTHORISED MEMBER OF THE PRACTICE

INVESTIGATION AND PREVENTATIVE TREATMENTS				
Code	**Treatment**	**Qty**	**Treatment date**	**€ Fee**
120	Examination			
150	Extensive examination			
180	Periodontal examination			
230	X-rays small (each)			
272	X-rays bitewing series			
330	X-rays panoramic or complete series			
240	X-rays occlusal			
1110	Scale & polish			

EMERGENCY TREATMENT (OUT OF HOURS)				
Code	**Treatment**	**Tooth no. required**	**Treatment date**	**€ Fee**
9110	Treatment of dental pain			
2940	Protective restoration			
9630	Prescriptions			

BASIC TREATMENTS: FILLINGS & SEALANTS		Surface required for fillings		
Code	**Treatment**	**Tooth no. required**	**Treatment date**	**€ Fee**
1351	Fissure sealant			
2140	Silver filling			
2150				
2160				
2161				
2391	White filling			
2392				
2393				
2394				

BASIC TREATMENTS: PERIODONTAL		Tooth no. required	Treatment date	€ Fee
4341	Perio scaling			
4910	Perio maintenance			
4355	Full mouth debridement			
BASIC TREATMENTS: EXTRACTIONS		**Tooth no. required**	**Treatment date**	**€ Fee**
7140	Tooth extraction (general practice)			
7210	Surgical extraction (specialist)			
BASIC TREATMENTS: CROWNS		**Tooth no. required**	**Treatment date**	**€ Fee**
2930	Stainless steel crown			
MAJOR TREATMENTS: CROWNS, INLAYS AND ONLAYS		**Tooth no. required**	**Treatment date**	**€ Fee**
DO25	Onlay			
DI26	Inlay			
2752	Porcelain crown			
2952	Post & core			
2920	Recement crown			
2980	Repair crown			
2962	Porcelain veneer			
2960	Composite veneer			

MAJOR TREATMENTS: BRIDGES & IMPLANT CROWNS		Tooth no. required	Treatment date	€ Fee
6242	Pontics			
6752	Bridge retainer			
6058	Implant crown			

MAJOR TREATMENT: ROOT CANALS		Tooth no. required	Treatment date	€ Fee
3310	Root canal canine or incisor			
3320	Root canal premolar			
3330	Root canal molar			
3220	Pulpotomy			

MAJOR TREATMENT: DENTURES		Date	€	Tooth no. required		(TN)	Date	€
5110	Full upper			5213	Chrome P/-			
5120	Full lower			5214	Chrome -/P			
D57R	Reline			5211	Acrylic P/-			
D56R	Repair			5212	Acrylic -/P			
5650	Adjustment							

IMPLANT UPGRADE		Tooth no. required	Treatment date	€ Fee
6010	Dental implant			

ORTHODONTICS		Date treatment commenced	Estimate treatment length in months (IOTN)	€
8030	Limited ortho treatment			
8060	Interceptive ortho treatment			
8080	Comprehensive treatment child up to 18			
8090	Comprehensive treatment adult (IOTN Needed)			

BASIC TREATMENTS: SPACE MAINTAINERS (CHILDREN)		Date appliance fitted	Missing tooth number(s)	€
D1505				

Miscellaneous items List all other treatments not listed above	
TOTAL VALUE OF CLAIM	

SECTION C DENTIST DETAILS: TO BE SIGNED BY A DENTIST

I confirm that the above patient has received the treatment detailed above.

DENTIST DETAILS AND STAMP	
IDC/GDC number	
Name	
Signature	
Practice phone number	
Vhi dental network number	

PRACTICE STAMP