Dental treatment claim form

ALC GLOBAL HEALTH INSURANCE
AN IMG COMPANY

Filling out this form

- Use this form to make a claim for Dental treatment.
- Make sure you answer all questions and sign the declaration.
- Please write clearly using capital letters.
- If you have any questions, call us on +44 (0) 330 333 6686

What's next?

Send your completed form to us together with your claims documents, including invoices, payment receipts and any medical reports using **one** of the following options. Please note that you must keep your original invoices and receipts for 6 months for audit requirements other than sending by post when originals should be included, in which case photocopies should be kept.

Online: https://claims.alchealth.com
Email: claims@alchealth.com
Fax: +44 (0) 330 333 6687
Post: ALC Health Claims Team,
PO Box 1114 Cardiff CF11 1UL United Kingdom

1 Patient Details

Title
☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Date of birth (DD-MM-YYYY)

First name(s)

Policyholder's first name(s)

Last name(s) / Surname(s)

Customer Number

Condition ID or Case Reference (if available)

Contact Mobile Number(s)

Email address

By providing an email address and mobile phone number, you agree to electronic notifications (including email and SMS) for the purpose of processing your claims.

2 Payment details

Please confirm who we should send payment to: Pay Provider ☐ Reimburse Policyholder/Patient (complete the below) ☐

Account Holder Name (exactly as registered with your bank)

Currency to be paid in

Account Number / IBAN (Your account number can be 8 to 34 digits. Outside of UK, please enter IBAN, example of an IBAN: GB17BUKB20182703450546)

Bank name

Bank address

Sort Code (Account held in the UK only)

Postcode

Country

Swift or BIC Code (Account held outside of the UK, This code is 8 or 11 characters and is the unique identifier to your bank, examples: AIBKGB2X or BARCGB22XXX)

Routing Code

BSB/ABA/Transit Code

We recommend you contact your bank to confirm the correct payment details to ensure you receive funds being sent from the UK. Some countries and banks require additional information when receiving international payments.

3 Description of expense

Please tick, then give details on the right	Amount charged (and currency)	Treatment date (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, including treatment for an abscess, rebuild of a cracked or broken tooth or temporary filling.		
☐ Orthodontic treatment (to move teeth or adjust underlying bone) when medically necessary for oral health.		
☐ Accidental Damage caused to sound, natural teeth damaged or lost in an accident. Treatment must take place within 5 days of the accident.		
☐ Dental surgery in a hospital by an oral and maxillofacial surgeon or surgical dentist. Includes surgical removal of impacted or buried wisdom teeth and extractions of complicated buried roots.		
☐ Apicectomy performed in a hospital by an oral and maxillofacial surgeon or surgical dentist.		

Is the claim the result of an accident?
Yes ☐ No ☐
If yes, provide details of how, when and where the accident happened

Was there another person/company involved in the accident?
Yes ☐ No ☐
If yes, provide the insurer's name, contact details and third party's policy number

Does the patient hold any other insurance plan or policy that could also provide cover for these medical costs?
Yes ☐ No ☐
If yes, what type of insurance plan or policy

Please include the insurer's name, contact details and patient's policy number

Please review your policy wording, claims submitted later than 6 (six) months after the end of the period of cover may be denied.

Reason for late submission if more than 6 (six) months after the end of your policy period.

4 Declaration and consent

Your claim will be managed by ALC Health or another third party on behalf of ALC Health.

I confirm I have read the information in this form. I wish to make a claim and declare that all the information I have given you is, to the best of my knowledge, true and correct.

- I consent to ALC Health reviewing the information in any medical reports or health records that may be requested.
- I consent to ALC Health sharing the medical and health information contained in this form, a health record or any medical reports with the underwriters of my policy.
- I consent to the medical practitioner, and/or hospital involved in the patient's care reviewing medical or treatment details and discharge arrangements with ALC Health.

☐ I declare that I am the patient
▶ if the patient is under 16, a parent or guardian should mark this box and sign below on behalf of the patient ☐

Name of parent or guardian

Relationship to patient

☐ I wish to see any report from the medical practitioner before it is sent to you

☐ I agree to receiving benefit statements and personal medical information via email

Patient signature (to be signed by the parent/guardian if the patient is under 16)

Date signed (DD-MM-YYYY)

Patient name

5 Dental certificate – to be completed by the Dental Practitioner

Dental chart

Please complete this chart or attach your existing treatment plan and dental chart along with this application.

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

Insert the relevant code(s) below into the boxes above to describe what treatment was given to which teeth.

Accidental damage	AD	Repair of crown or 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 inlay	NC		

Examinations and treatment

Date of examination (DD-MM-YYYY)

Date of routine examination, if applicable (DD-MM-YYYY)

Date of cleaning, if applicable (DD-MM-YYYY)

Does the patient require further treatment?

☐ No

☐ Yes ▶ when is the proposed date? (DD-MM-YYYY)

Full details of the condition requiring treatment/surgery

Full name

Address

Postcode Country

Qualifications

Telephone number

Fax number

5 Dental certificate – to be completed by the Dental Practitioner continued

Date that this condition was first diagnosed

Full details of the proposed treatment/surgery

If the patient has been referred to an oral and maxillofacial surgeon, please give their full details below.

Signature

Date (DD-MM-YYYY)

Official stamp

6 Important information

Please read carefully and keep for your records

Access to Medical Reports Act 1988:

You need to understand these rights before you agree to us requesting a report from the medical practitioner treating you.
These rights do not relate to reports from practitioners who are not responsible for treating you. Also, when we ask for information from your medical records such as a copy of your medical notes, only the first point applies.

- You can withhold your consent, but if you do so, we might not be able to process your claim.
- If we need a report we will write to you to tell you the date it was requested.
- You can indicate in the box in section 4 Declaration and consent of this form if you would like to see any report from the medical practitioner before it is sent to us. You have 21 days from the date of our request to do this and it is up to you to contact the medical practitioner. If you change your mind before the report has been sent to us, you can contact your medical practitioner to see it. You have 21 days from the date of our request to do this.
- If you disagree with the information in the report, you can contact the medical practitioner to change it. If the medical practitioner does not agree with you, they will ask you to write a statement to be attached to the report that is sent to us.
- You can ask the medical practitioner to see the report at anytime within six months of the medical practitioner sending it to us.
- Your medical practitioner may charge you for a copy of the report. This charge is not covered by your scheme/policy.
- Your medical practitioner does not have to show you parts of the report if they think it could cause harm to your physical or mental health.
- If the report includes information about someone else, the medical practitioner will not show you that part of the report.
- If the medical practitioner does not want you to see part of their report, they will tell you in writing, but you can still view other parts of the report.

General Data Protection Regulation (GDPR):

Information about health, medical history and any treatment that you have is sensitive personal information.

- We need your consent to process your sensitive personal information.
- If you would like to know what information we hold about you or to request erasure, please contact us.
- For a full description of how we gather and use your personal information and your rights under GDPR, please review our Privacy Policy at https://alchealth.com/privacy.htm

Auditing and the prevention and detection of crime.

We may audit the records of medical practitioners and hospitals to:

- Ensure that we are being correctly billed for their services;
- Prevent and detect crime, particularly fraud; or
- Review the performance of specialists.

Audits may be part of a programme or in response to a specific circumstance and may involve reviewing customers' medical records held by the person or organisation being audited.

We may need to share information that we receive with third parties. This includes medical experts, other insurers, the NHS Counter Fraud Security Management Service and the General Medical Council. We are required by law, in certain circumstances, to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crimes.

This may involve adding non-medical information to a database that will be viewed by other insurers and law enforcement agencies. We are required to notify the General Medical Council or other relevant regulatory body about any issue where we have reason to believe a medical provider's fitness to practice may be impaired.

CM0050A2308240228

ALC Health is a trading name of International Medical Group Limited and IMG Europe AB.

International Medical Group Limited is authorised and regulated by the Financial Conduct Authority (311496). Registered in England & Wales (4163178). Registered office: 254 Upper Shoreham Road, Shoreham-By-Sea, West Sussex, BN43 6BF.

IMG Europe AB is authorised and regulated by the Swedish Financial Supervisory Authority (71922) and is registered as an Authorised Representative by the Financial Conduct Authority (1003200). Registered in Sweden (559405-0469). Registered office: c/o SiriusPoint International, Fleminggatan 14, 112 26, Stockholm, Sweden. UK establishment (BR025974) office address: 3rd Floor, Fitzalan House, Cardiff, CF24 0EL, UK.

0424