DENTAL CLAIM FORM

This form is for claims relating to routine dental treatment/dental treatment only. If you are claiming for emergency treatment, dental injury or hospital cash benefit please call the Bupa Dental helpline number on your membership certificate to check your benefits and to request an additional form.

Please ensure that you complete this form fully and return it to us. The last page of this claim form includes a declaration which you are required to read and sign. Failure to do so may cause delays in the processing of your claim.

When you have completed the form please send it to: Bupa Dental, Anchorage Quay, Salford Quays, M50 3XL. If you need to speak to someone regarding your claim, please call the Bupa Dental helpline.

Please read the following before you complete the form:

- all claims must include an original dated receipt and where possible an invoice which contains details of the treatment
- the dental treatment details and dentist's declaration should be completed by your dentist or an authorised member of the dental practice who may make a small charge for this service. The fee will not be refunded by Bupa
- only treatment itemised on this claim form can be claimed for subject to the rules of the scheme
- please quote your membership number on all correspondence
- all claims are paid in sterling
- please ensure you enclose original (not photocopied) documents with your completed form
- claims need to be submitted within six months of treatment unless that was not reasonably possible

PLEASE USE BLOCK CAPITALS TO COMPLETE THE FORM

MAIN MEMBER DETAILS

Your Bupa membership number:

Main member title (Mr, Mrs, Miss, Ms, other title)

Forenames: | Surname:

Address:

Date of birth:

Contact numbers:
Daytime: | Evening: | Mobile:

Email:

Fast track claims
If you have no objection, in an effort to promote speedier and more customer friendly claims handling, we may find it easier to telephone and/or email you during the course of our normal working hours to discuss your claim and/or request further details.

☐ If you do not wish to be contacted by either of these methods then please tick this box.

CLAIMANT'S PERSONAL DETAILS (If the claimant is not the main member)

This section should be completed by the person undergoing treatment if they are not the main member, or a parent/guardian if the patient is under 16.

Claimant's title: (Mr, Mrs, Miss, Ms, other title)

Forenames: | Surname:

Please tick appropriate box and add details below if the patient receiving treatment is a partner or dependant covered on your policy.

☐ Partner ☐ Child/Dependant

Date of birth: ☐ Male ☐ Female

DENTAL TREATMENT DETAILS

This section should be completed by your dentist or an authorised member of the dental practice.

Procedure codes	Treatments	Tooth notation	Number of treatments or teeth	Treatment date(s)	Total patient's charge
DA001	EXAMINATION				
DA002	EXAMINATION NEW PATIENT				
DA004	SMALL X-RAY				
DA005	MEDIUM X-RAY				
DA006	PANORAL X-RAY				
DA007	SIMPLE SCALE AND POLISH				
DA012	CHRONIC PERIODONTAL 1-4 TEETH				
DA013	CHRONIC PERIODONTAL 5-9 TEETH				
DA014	CHRONIC PERIODONTAL 10-16 TEETH				
DA015	CHRONIC PERIODONTAL 17 OR MORE TEETH				
DB001	AMALGAM (1 SURFACE)				
DB002	AMALGAM (2 SURFACE)				
DB003	AMALGAM (3 SURFACE)				
DB004	COMPOSITE ANTERIOR (1 SURFACE)				
DB005	COMPOSITE ANTERIOR (2 SURFACES OR MORE)				
DB028	COMPOSITE POSTERIOR 1 SURFACE				
DB029	COMPOSITE POSTERIOR 2 SURFACES OR MORE				
DB007	ROOT CANAL TREATMENT - SINGLE ROOT				
DB008	ROOT CANAL TREATMENT - TWO ROOTS				
DB009	ROOT CANAL TREATMENT - MULTIPLE ROOTS				
DB011	EXTRACTION (PER TOOTH)				
DB013	SURGICAL EXTRACTION (FLAP RAISED)				
DB015	APICECTOMY				
DB017	INCISING OF ABSCESS				
DC001	ACRYLIC PARTIAL UPPER OR LOWER DENTURE				
DC002	ACRYLIC PARTIAL UPPER AND LOWER DENTURE				
DC003	ACRYLIC FULL UPPER OR LOWER DENTURE				
DC004	ACRYLIC FULL UPPER AND LOWER DENTURE				
DC005	METAL PARTIAL UPPER OR LOWER DENTURE				
DC006	METAL PARTIAL UPPER AND LOWER DENTURE				
DC009	DENTURE - ADDITION OF TOOTH				
DC011	REPAIR DENTURE				
DC012	VENEER (PER TOOTH)				
DC013	INLAY/ONLAY PER TOOTH				
DC017	ADHESIVE BRIDGE				
DC018	BRIDGE PER UNIT				
DC019	PORCELAIN CROWN				
DC020	FULL GOLD CROWN				
DC021	PORCELAIN BONDED TO METAL CROWN				
DC022	CAST POST AND CORE				
DC023	PREFAB POST AND CORE				
DC025	RELINE DENTURE				
DC030	REFIX OR RECEMENT EXISTING CROWN				
DC031	RECEMENT ADHESIVE BRIDGE				
DC032	RECEMENT OTHER BRIDGE				
DB020	OCCUSAL SPLINT				
DB021	ANAESTHETISTS CHARGES				
DB036	ORTHODONTIC CHARGES*				

*Orthodontic charges relate to under 18s only. Benefit available for Bupa Dental Plan and Bupa Dental Choice members only subject to your benefit limits.

DENTAL TREATMENT DETAILS (CONTINUED)

If the treatment has been received under the NHS please complete the box below:

NHS Banding	Treatment band given (please tick)	Patient Charges
Band 1		
Band 2		
Band 3		
	Total treatment cost	£

DENTIST'S DECLARATION

Bupa Dental Centre tick yes ☐ or no ☐ Location:

I confirm that the patient received the dental services itemised in the 'Dental treatment details' section on the date(s) specified and to the value shown.

Signature	Dentist's stamp
Name:	
Position:	
Date:	

CLAIM DETAILS

This section should be completed by you, please ensure that the original dated receipts are enclosed.

Total treatment cost	£	Number of receipts enclosed

PAYMENT DETAILS

You can receive payments for claim settlement direct to your chosen bank or building society account, helping to make settling your claim safer and more timely. This simply means that instead of posting a cheque to you we can automatically pay your claim by BACS (Bank Automated Clearing System). If you would like to be paid via BACS please ring the member helpline who will be able to help you or download the form from bupa.co.uk/bacs and send it back to us.

If you would like to receive a cheque payment on this occasion, please tick this box. ☐

BUPA DATA PROTECTION NOTICE

Confidentiality: The confidentiality of patient and member information is of paramount concern to the companies in the Bupa Group. To this end, we fully comply with Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be outside of the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your GP or to their agents and if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the main member.

Telephone calls: In the interest of continuously improving our services to members, calls may be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by us, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Names and addresses: Bupa does not make the names and addresses of members available to other organisations.

Keeping you informed: The Bupa Group would, on occasion, like to keep you informed of The Bupa Group's products and services which we consider may be of interest to you.

Contact address: If you do not wish to receive information about our products and services, or have any other Data Protection queries, please write to the Bupa Group's Head of Information Governance at: Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at: DataProtection@bupa.com

CLAIMANT DECLARATION

Please read the following carefully before signing the declaration

Prior to returning the claim form please study the policy wording and read the terms and conditions as they relate to your claim. Please note that we are not responsible for the costs of obtaining documentation in support of the claim. The information on this form will be used by us to deal with any claim. Insurers share information to prevent fraud.

Declaration:

I/We consent that Bupa Dental may contact my dentist to obtain clinical records from my dentist that can be used to support this claim.
I/We declare that the information contained within this claim is true and correct to the best of my/our knowledge and belief.
I/We have not withheld any information from Bupa Dental Insurers within my/our knowledge connected with this claim.

Signature of claimant:	Date: