Dental Expenses Claim Form

Please complete this form using **BLOCK CAPITALS** and **BLACK or BLUE INK ONLY**

Please complete all sections of the claims form in BLOCK CAPITALS and ensure that all original invoices and receipts are attached.
The declaration on this form must be signed and dated by the patient or by the main policyholder if the patient is under the age of 18. Failure to do so may result in delays in the processing of your claim.

If you have made a claim for the same dental condition before, please state the claim number where possible:	

1. Patient Details

Full Name:	Date of Birth:
Postal Address:	Telephone Number:
	Email Address:
Policy Number:	Member ID:

2. Policy Details

Name of Main Policyholder:	
Policy Number:	Member ID:

3. Bank Account Information

Name of Account Holder:	
Account Number:	Sort Code:
IBAN*:	Swift/BIC*:
Claim Payment Currency:	
Bank Name and Postal Address:	

Please fill out your bank details above so that we can pay your claim into your bank account of choice. Please note that we are unable to refund your claim to a debit or credit card.
*Note: This information is required for payments to be made outside of the UK. Please contact your bank if you do not have these details. If currency type is missing the default currency will be paid in USD.

4. Additional Information

Does the patient hold any other insurance plan/policy that could also provide coverage for these medical costs?
Yes ☐ No ☐

If Yes, provide the other insurer's name and contact details, and include the patient's plan or policy number with that insurer:

Is the claim the result of an accident? Yes ☐ No ☐

If Yes, provide the circumstances of how, when and where the accident occurred:

Was there another person/company involved in the accident? Yes ☐ No ☐

If Yes, provide the name of the person/company involved, insurer's name, contact details and their policy number:

5. Claims Information

Confirm the reason for visiting the dentist and include details of the symptoms/dental condition for which you have been treated:

6. Have you ever suffered from or received treatment for this dental condition before? Yes ☐ No ☐

If Yes, please provide details of previous episodes, including relevant dates and treatment provided:

7. If you suffered an injury, was this the result of an accident? Yes ☐ No ☐

8. Did the injury occur while you were taking part in a professional sport? Yes ☐ No ☐

If Yes, please confirm the circumstances of the accident, including how it happened, the location and the date and time:

Provide brief details of the treatment and investigations:

9. Please provide a breakdown of the invoices being submitted with this claim:

Invoice reference	Invoice date	Treatment date, if different	Amount (including currency)

*Use a separate sheet if you need more space.

10. Has further treatment for your condition been planned? Yes ☐ No ☐

If Yes, please provide details of the treatment plan:

11. Declaration

Global Benefits Advisors have appointed Healix International to manage your claims on their behalf.
I confirm I have read the information in this form and declare that all the information I have given is, to the best of my knowledge, true and correct.
I consent to Healix International reviewing the information on this form.

Signature:	Print Name:	Date:

DENTAL CERTIFICATE

In order for Healix International to process your claim as quickly as possible, you can take this to your consultation with you, have it completed by the treating dentist and send this when you submit your claim. If you choose not do so, it may be necessary for Healix International to return to you to have this completed if required.

-

To be completed by the patient:

I, the patient, hereby authorise Healix International to obtain further medical information from the dentist completing this medical certificate should it be required for the purpose of this claim.

Signature: _____ Date: _____

To be completed by the Dental Practitioner

Patient Details:

Full Name:	Date of Birth:
Date the patient first registered with you/the clinic/the hospital:	

Please provide details of the symptoms that the patient was suffering from:	
What date did the patient first notice these symptoms?	
What date did the patient first present these symptoms to you or any other medical practitioner?	
To your knowledge, or in your medical opinion, has the patient ever suffered from these or any related symptoms in the past? If so, please provide details:	

Please provide details of any tests and investigations that the patient has had, and the results of these:

Would you consider the condition to be?	Acute? ☐ Chronic? ☐ An acute episode of a chronic condition?

If this diagnosis is related to any previous condition suffered by the patient, please provide details, including any previous investigations, treatment received and the relevant dates:

Is there any underlying cause or condition? If so, please provide details:

Is the condition a result of an accident?	Yes ☐ No ☐
If so, was the patient under the influence of alcohol or any other intoxicating substance at the time of the accident?	Yes ☐ No ☐

Please complete the following dental chart using the abbreviations below:

	Left								Right								
Treatment																	Treatment
Finding																	Finding

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

Finding:

b = bridge
c = crown
ca/da/dn = caries/decay/dental necrosis
cl = calculus
g = gap closure
gb = gingival bleeding
gi = gingivitis
gs = gingival swelling
i = implant
in = inlay
m = missing tooth
p = periodontis
pu/od = pulpitis or odontitis

Treatment:

AF = amalgam fi lling
CF = composite fi lling
D = denture
E = extraction
I = implant
IN = inlay
M = metal ceramic crown
NB = new bridge
NC = new crown
O = orthodontics
ON = onlay
OR = oral radiograph
PR = panoramic radiograph
RB = replacement bridge
RC = replacement crown
RCT = root canal treatment
S&P = scale and polish

What is the further treatment plan required, if any?

I hereby certify that I am currently treating the above named patient for this medical condition and that the information I have provided is correct to the best of my knowledge. I understand that the accuracy of the information provided may affect my patient's claim for private medical treatment.

Name of Dental Practitioner:		Telephone:	
Address		Qualifications:	
Signature:		Practice Stamp:	

Completed forms can be either emailed to: internationalhealthcare@healix.com or
FAXED to: 011 44 20 8481 7826