Supplementary worldwide dental accident and emergency
Claim Form for Emergency Treatment away from Home

This claim should be completed to claim under section 1a (Emergency Treatment away from Home) of the policy. If your claim falls under another section of the worldwide dental accident and emergency cover, please complete the specific claim form accordingly, available from your registered dental practice.

How to complete and submit your claim form

Please complete all sections and write clearly in BLOCK CAPITALS using black or blue ink.

This form, countersigned by the treating dentist (or your registered dentist) must be sent to the Insurance team at PPD within 30 days of the emergency (60 days if the incident occurs overseas). Costs will be reimbursed up to the limits shown in the Policy. Any amount which exceeds the specified limit must be paid directly by you to the treating dentist. You must provide all necessary reports, receipts, and other documentation in support of the claim when asked to do so.

Reference to the policy wording will assist you in completing this form. If you have any questions regarding making a claim please contact your dental practice or call the claims help line on 01482 213 215

Please return scans of completed claim forms by email to: ppd@jelf.com

Alternatively, please post hard copies to: Patient Plan Direct Claims Partnership House Priory Park East Hull HU4 7DY

IMPORTANT – Please note, we will require a copy of your payment receipt from the practice you visited, clearly outlining all charges for your appointment and any treatment.

We will not make payment if you visited a dental practice within a 25 miles radius of the dental practice with which you are registered. We will also not make payment where you have been outside the United Kingdom for longer than 90 consecutive days.

Patient Details

Full name	
Date of Birth	
Address	
Postcode	
Telephone number(s)	/
Email Address	
Plan reference number *(available from your registered practice)*	

Treating Dentists Details

Full name	
Practice	
Practice Address	
Country	
Postcode / ZIP code / Area Code	
Telephone number	
Email Address	

Your Registered Practice Details

Dentist name	
Practice	
Practice Address	
Postcode	
Telephone number	
Email Address	

Emergency Appointment and Treatment Details

Did the accident occur outside of the UK?	Yes / No
If you were outside of the UK, what date did you leave for your trip and when did you return?	Date left UK: Date returned to UK:
Emergency Appointment Date & Time	Date: Time:

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Please provide details of any treatment provided during the emergency appointment and associated costs

Treatment	Tick	Cost (£)
Examination and treatment of sensitivity		
X-ray examination		
Tooth extraction (maximum two teeth)		
Root extirpation to include dressing and for temporary filling and treatment of infections, Number of canals _____________		
Treatment of infection to include prescriptions		
Provision of a filling, Number of fillings ______________		
Re-secure crown or inlay		
Re-secure bridge		
Provision of temporary crown		
Provision of temporary bridge		
Provision of temporary post or core		
Treatment to stop haemorrhage		
Removal of sutures placed by another dentist		
Repair/adjustment of orthodontic appliance		
Adjustment to denture		
Repair of denture to include re-fixing of teeth and gums and repair of clasp		
Other emergency dental treatment (please detail below)		

Payment Details

Payment will be transferred to your bank account from where regular plan fees are collected.

Using your personal information

We collect and process information about you in order to provide insurance policies and to process claims. Your information is also used for business purposes such as fraud prevention and detection and financial management. This may involve sharing your information with, and obtaining information about you from, our group companies and third parties such as brokers, loss adjusters, credit reference agencies, service providers, professional advisors, our regulators or fraud prevention agencies. For further information on how your information is used and your rights in relation to your information please request to review a copy of our privacy policy.

Patient Declaration

I declare that (a) this form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of the claim have been disclosed.

Name | **Signature** | **Date**

Dentist Declaration

I declare that (a) this form has been completed after proper enquiry; (b) its contents are true and accurate and (c) all facts and matters which may be relevant to the consideration of the claim have been disclosed.

Name | **Signature** | **Date**