



wpa.org.uk

Dental claim form.

Corporate Clients.

LARGE PRINT CLAIM FORMS ARE AVAILABLE UPON REQUEST.

Please complete in black ink using BLOCK CAPITALS and return this form to the address shown on the back page.

Please ensure your dentist completes section 3 & 4 on the back page.

Important: If you are charged for completing this form you cannot claim this back from WPA.

In the event of a Dental Injury - you must inform WPA (by calling 01823 625230) and have the emergency appointment both within 72 hours of the injury.

In the event of diagnosis of a defined oral problem (oral cancer, bone cyst of the jaw, tumour of the mouth or jaw, conditions of the salivary glands, surgical removal of retained buried roots, surgery to the temporomandibular joint), you must contact WPA (by calling 01823 625230) within 72 hours of the diagnosis.

YOUR DETAILS

Patient customer number _____

Patient name _____

Date of birth (dd/mm/yy) _____

Phone number (home / work / mobile) _____

E-mail address _____

Address (if changed) _____



Providing your e-mail address

We recognise that communicating by e-mail is quick and efficient but carries no absolute guarantee of confidentiality. By providing your e-mail address on this form you are consenting to its use for services which may include claim and medical information as well as the administration of your policy.

Does this claim relate to an injury for which you may claim from a third party? No Yes *If YES we will send you a leaflet outlining your options*

1. YOUR CLAIM

What is the total value of the receipts you are attaching _____

What prompted you to seek treatment _____

A ROUTINE APPOINTMENT

AN EMERGENCY APPOINTMENT *In the event of a Dental Injury you must contact us on 01823 625230 and have the emergency appointment within 72 hours of the injury.*



Routine Appointment

Covers treatment performed by a registered dental surgeon or registered dental hygienist in a general dental surgery.



Emergency Appointment

Covers treatment for incidences of acute pain, swelling or a dental haemorrhage requiring an emergency dental appointment.

Please specify the reason for the emergency appointment Acute pain Swelling Haemorrhage

When did the emergency appointment take place _____ (dd/mm/yy)

Dental Injury or Defined Oral Problem *Do NOT complete this form, please contact WPA by calling 01823 625230 within 72 hours of the injury or diagnosis.*

2. POLICYHOLDER'S/PATIENT'S DECLARATION

- I declare that:
- the dentist is my/the patient's normal dentist; and
 - the information given on this form is accurate and complete; and
 - WPA can rely on this information in paying my claim.

By signing this form I confirm that I have read the current rules of the policy and understand them. I consent to a report being supplied, in confidence, by my/the patient's medical attendant if required by WPA. I also consent to your processing my personal data, and that of the patient, in accordance with WPA's current data protection notification as set out in 'A Guide to Your Policy'.

Signature of either The Patient – if over 16, OR The Policyholder – if the patient is under 16

Date (dd/mm/yy) _____

Claims

WPA pays claims in good faith, however we have a duty to all policyholders to contain premium levels, to detect and prosecute fraudulent claims. On a sampled basis we investigate claims in detail and to this end you may be required to provide further information. The request for such information should not imply any form of wrongdoing, being part of a structured audit process.



3. WPA DENTAL SCHEDULE – DENTIST TO COMPLETE FOR ALL EMERGENCY APPOINTMENTS AND FOR ROUTINE APPOINTMENTS WHERE THE INVOICED AMOUNT EXCEEDS £120.

Please refer to your Guide for the overall benefit limit that applies to your policy.

Item	Dentist's Charge	Item	Dentist's Charge
OUT OF HOURS ATTENDANCE FEE		ROOT FILLINGS	
40001	Out of hours telephone consultation with patient	40042	Incisor/canine
40002	Registered dentist	40043	Pre-molar
40003	Registered dental surgery assistant	40044	Molar
MISCELLANEOUS		40025	Apicectomy
40004	Consultation, examination and report	EXTRACTIONS	
40006	Radiographs (a) small	40012	One tooth
40007	Radiographs (b) panoral	40013	Multiple
40005	Provision of prescription antibiotics/analgesics	40041	Surgical extraction
40008	Sedative dressings – 1st tooth	CROWN & BRIDGE	
40009	Sedative dressings – multiple	40026	Ceramic crown
AC101	Sedation	40027	Bonded crown – precious metal
40011	Incising an abscess	40028	Cast gold crown
40010	Arrest of haemorrhage	40040	Gold/ceramic inlay
40014	Root canal treatment, opening and dressing	40029	Bridgework - precious metal
40015	Root canal treatment, opening and dressing	40030	Re-cement crown/bridge/inlay
40049	Scale and polish/consultation with hygienist	40016	Temporary crown
FILLINGS		40032	Temporary bridge
40019	Single surface	NHS DENTAL FEES	
40020	Two surface	40050	Band 1 course of treatment
40021	Multi surface	40051	Band 2 course of treatment
40022	Pin retention	40052	Band 3 course of treatment

4. DENTIST'S DECLARATION – DENTIST TO COMPLETE

I confirm that the above fee schedule has been completed and declare that the treatment details provided are in every respect accurate and complete.
I confirm this claim is not related to replacement or repair of dentures or implants.

Full name of dentist _____

GDC NUMBER _____

It is ESSENTIAL you give your GDC number for the claim to proceed

Dentist's signature

X _____ *X*

Address/ Practice Stamp

Date _____ (dd/mm/yy)

5. PAYMENT INSTRUCTION

You can choose to have the reimbursement of your cash plan claims made directly into your bank account by direct credit or paid by cheque. If you would like to take up the direct credit option please complete the following section in full. Once your account details have been validated all subsequent payments for all cash plan claims for each individual covered by your plan will be made into this account. By signing this section you (the policyholder) are agreeing to these terms and conditions. **Please note that if you do not fill in the following section your payment will automatically be made by cheque.**

Name(s) of Account Holder(s) _____

Bank/Building Society Name _____

Bank/Building Society Account Number _____

Branch Sort Code _____ Policyholder signature

X _____ *X*

Western Provident Association Limited

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