Dental insurance.
Claim form.

Before you begin

Please complete this form using BLOCK CAPITALS and BLACK INK

Please send this completed claim form with copies of your itemised receipts to: **Bupa Dental, Bupa Place, 102 The Quays, Salford M50 3SP**. Alternatively, you can submit your claim online at **bupa.co.uk/dental/finance-and-insurance/make-claim**

Please note that you will only be reimbursed up to the maximum annual benefit limits specified on your Membership Certificate and in your Membership Guide. We recommend that you check your benefit limits before undertaking any treatment as you will be liable for any costs that exceed this. If you have any questions regarding your claim or benefit limits, please call us on the Bupa Dental helpline **0800 237 777***.

Please ensure that all relevant sections have been completed and the declaration has been signed. This will help us deal with your claim as quickly as possible. You also need to send us a **fully itemised receipt** for your dental treatment, showing the name and contact details of the dental professional, date and type of treatment, and the name of the person who has had the treatment. Providing we have all the information we need from you, you can expect your claim to be processed within seven to ten days.

Contacting you in relation to your claim

We may contact you regarding your claim by text and/or email to keep you updated and ask questions, so we can settle your claim as quickly as possible.

If you do **not** wish to be contacted by text or email please tick this box. ☐

Written advice of payment will be posted to you.

*The customer service helpline is open 8am to 6pm Monday to Friday and 8am to 1pm Saturdays. We are closed public holidays. We may record or monitor our calls.

Bupa membership number ☐☐☐☐☐☐☐☐☐☐

Main member name

Title *(please tick or list title if other)* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name(s) Surname

Address

Postcode

A. Claimant details (person completing the claim form)

To see how we use your information, please read our privacy notice online at bupa.co.uk/privacy

Title *(please tick or list title if other)* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name(s) Surname

Date of birth D D M M Y Y Y Y

Address if different to main member

Postcode

Telephone number Mobile telephone number

Email address

B. Payment details

Account holder name

Bank/building society name

Sort code ☐☐ - ☐☐ - ☐☐

Account number ☐☐☐☐☐☐☐☐

If you don’t provide your bank account details, we will settle your claim by cheque.

C. Patient details (person who received treatment)

The patient receiving the treatment must be named on your membership certificate.

Title *(please tick or list title if other)* Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name(s) Surname

Date of birth D D M M Y Y Y Y

Address if different to main member

Postcode

Telephone number Mobile telephone number

Email address

D. Treating dentist

Is your dentist part of the Bupa Dental Insurance Network? Yes ☐ No ☐ Don’t know ☐

Dentist’s phone number

Name of dentist

Name of practice

Address

Postcode

E. Routine and restorative dental treatment

Please complete this claim form in conjunction with your membership guide which sets out your benefits, benefit limits, exclusions on benefits and qualifying periods.

Complete this section if you are claiming for routine dental treatment. Please tick to indicate the type of treatment received and whether it was completed via an NHS or Private Dentist, provide treatment date(s) and also the amount to be claimed against each box ticked. You can find this information on the invoice you received from your dentist.

Type of treatment	Private	NHS	Treatment date(s)	Amount claimed
Routine examination				£
New patient/specialist examination				£
Small X-ray (bitewing)				£
Small X-ray (intra-oral)				£
Other X-rays (panoral or OPG)				£
Simple scale and polish (Hygiene)				£
Silver/amalgam fillings (one surface)				£
Silver/amalgam fillings (two surfaces)				£
Silver/amalgam fillings (three surfaces)				£
White filling anterior (one surface)				£
White filling anterior (two surfaces or more)				£
White filling posterior (one surface)				£
White filling posterior (two surfaces or more)				£
Simple extraction				£
Surgical extraction with bone fragment				£
Apicectomy				£
Incising an abscess				£
Root canal treatment				£
Inlay/onlay				£
Veneer				£
Full gold crown				£
Porcelain crown				£
Bonded crown				£
Bridge				£
Adhesive bridge				£
Post and core gold				£
Post and core standard				£
Refix or re-cement existing crown				£
Re-cement adhesive bridge				£
Re-cement any other bridge				£
Chronic periodontal (1 to 4 teeth)				£
Chronic periodontal (5 to 9 teeth)				£
Chronic periodontal (10 to 16 teeth)				£
Chronic periodontal (17 or more teeth)				£

E. Routine and restorative dental treatment (continued)

Type of treatment	Private	NHS	Treatment date(s)	Amount claimed
Partial upper or lower acrylic dentures				£
Partial upper and lower acrylic dentures				£
Partial upper or lower metal dentures				£
Partial upper and lower metal dentures				£
Full upper or lower acrylic dentures				£
Full upper and lower acrylic dentures				£
Reline denture				£
Denture repair				£
Denture addition of tooth				£
Implant and abutment				£
Anaesthetist fees (sedation)				£
Fissure sealants				£
Topical fluoride solution				£
Mouthguards				£
Orthodontic treatment				£
Hospital cash benefit				£
			Total Claim Value	**£**

F. Dental emergency and dental injury treatment

Please indicate whether you are claiming for a dental injury or emergency dental treatment.

Dental injury

Was the injury a result of participating in a physical contact sport? Yes ☐ No ☐

If yes, were you wearing a mouthguard which was supplied and fitted by a dental professional? Yes ☐ No ☐

Emergency dental treatment

Was the emergency dental treatment urgently required in order to alleviate pain, an inability to eat or any acute dental condition which presents an immediate and serious threat to general health? Yes ☐ No ☐

Any treatment carried out at a follow-up appointment must be claimed from the general dental treatment benefit limits.

Date of injury/emergency D D M M Y Y Y Y Amount paid £

Please provide full details of the injury/emergency giving full details of the cause, circumstance and the treatment completed (please continue on another sheet if required).

F. Dental emergency and dental injury treatment (continued)

If you have been in an accident and are taking action against another party, we may contact your solicitor to ensure that any claims payments we make are included in your legal claim against the other party.

Solicitor's name

Reference number

Address

Postcode

Accident date D D M M Y Y Y Y

G. Claimant declaration

Please read the following carefully before signing the declaration.

Before sending us your claim form please check the terms and conditions in the membership guide as they relate to your claim. The information on this form will be used by us to deal with any claim. In order to detect, prevent and help with the prosecution of financial crime, we may share information with fraud prevention or law enforcement agencies, and other organisations. If we suspect fraudulent activity we may inform the person or organisation who administers or funds your Bupa services. Please note that we are not responsible for the costs of obtaining documentation in support of the claim.

Declaration

I consent that Bupa Insurance Services Limited may contact my dentist to obtain clinical records that can be used to support this claim.

I declare that the information contained within this claim is true and correct to the best of my knowledge and belief.

I hereby authorise Bupa to direct payment to the bank account specified above.

I have not withheld any relevant information from Bupa Insurance Services Limited within my knowledge connected with this claim.

Submission of this claim is validation that the content is true and accurate. Date D D M M Y Y Y Y

Checklist

Please ensure your receipt(s) detail the following:

Have you attached your receipt?

- ☐ full itemised receipt(s) from your dentist
- ☐ the date and type of treatment
- ☐ the full name of the person who received the treatment
- ☐ the name of the dentist

Have you completed the following sections?

- ☐ Main member name, policy number and address
- ☐ A 'Claimant details'
- ☐ C 'Patients details'
- ☐ E 'Routine and restorative dental treatment'
- ☐ signed and dated section G 'Claimant declaration'

If applicable, you may also need to complete:

- ☐ section B 'Payment details'
- ☐ section F 'Dental emergency and dental injury treatment' (you may need to attach an extra page if you run out of space)

Privacy notice

Our privacy notice explains how we take care of your personal information and how we use it to provide your cover.
A brief version of the notice can be found in your membership guide or the full version is online at **bupa.co.uk/privacy**

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