Hiscox supplementary dental accident and emergency claim checklist

This checklist can be completed along with the Dental injury and emergency claim form when making a claim to ensure all necessary detail is provided, assisting in dealing with your claim as quickly as possible.

Please return scans of completed claim forms and checklist by email to: ppd@insurance-partnership.com
or post hard copies to: Patient Plan Direct Claims Partnership House Priory Park East Hull HU4 7DY)

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 tick the relevant nature or your claim/s (tick more than one if applicable)

Emergency treatment away from home (policy section 1a)	☐	Hospital benefit (policy section 3)	☐
Emergency call out / our of hours (policy section 1b)	☐	Mouth cancer (policy section 4)	☐
Treatment following an accident (policy Section 2)	☐	Redundancy (policy section 5)	☐

Please complete the relevant section/s of the checklist below

	✓
For all claims (ANY TYPE)	
• Declaration signed by claiming patient and treating or your registered dentist	
• Patient or dentist to be reimbursed? (N.B. we can only reimburse your registered dentist directly) • Full details of treating dentist (if not your registered dentist)	

Delete as appropriate: Patient / Registered Dentist	
Name	
Practice	
Address	
Post code	
Tel	
Email	

Emergency treatment away from home (policy section 1a)	
• Treatment occurred at a practice more than 25 miles away from your own practice	
• Invoice for treatment sent as evidence with claim form	
Emergency call out / our of hours (policy section 1b)	
• Date and time of emergency call out / treatment specified	
• Invoice clearly itemises call out fee and any treatment sent as evidence with claim form	
Treatment following an accident (policy Section 2)	
• Full details of the accident clearly outlined including date and time	
• Treatment plan submitted before treatment commenced	
• Invoice clearly itemises all treatment/s sent as evidence with claim form	
Hospital benefit (policy section 3)	
• Full details of hospitalisation provided (complete in injury section of claim form)	
• Invoices for care sent as evidence with claim form	
Mouth cancer (policy section 4)	
• Full details of diagnosis provided (complete in injury section of claim form)	
Redundancy (policy section 5)	
• Redundancy claim form completed (this is different to injury and emergency claim form)	
• Full details and supporting documents and evidence of redundancy sent with claim form	

Dental injury and emergency claim form

Reference to the Supplementary Insurance Policy Document will assist you in completing this form. Should you require any assistance, please feel free to call the PPD insurance claims team on: 01482 213 215 .

This form, countersigned by the treating dentist must be sent to the Insurance team at PPD within 30 days of the injury, incident or emergency (60 days if the incident occurs overseas). Costs will be reimbursed up to the limits shown in the Policy. PPD will at its sole discretion settle the claim directly either to you or to the treating dentist. 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.

Dental Accident Claims: Please note that you may not claim more than £250 in total unless we have previously approved a treatment plan.

Dental Emergency Claims: The claim form must be sent together with the treating dentist's signed receipt showing details of the temporary treatment given.

1. Patient details

Full Name

Address

Postcode

Telephone

Email

Date of birth

Plan registration number

2. Registered dentist details

Full name

Practice name

Address

Postcode

Telephone

Email

3. Claim information

(i) Emergency claim

How did the emergency occur?

What treatment was required?

Please provide details of treatment provided?

Did the emergency occur outside the UK Yes ☐ No ☐

Date and time of emergency treatment

Did you call the helpline? Yes ☐ No ☐

Did you have to pay a call out fee? Yes ☐ No ☐

Dental injury and emergency claim form

If yes, please confirm the amount £

(ii) Injury claim

Date and time of accident or injury

How did the accident or injury occur?

The following section is to be completed by your dentist

Date treatment started

Date treatment completed

Please provide details of the treatment provided

If ongoing treatment is required, please provide details of planned treatment and expected costs

4. Data protection

By signing this form you consent to Hiscox using the information we may hold about you for the purpose of providing insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information or criminal convictions). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third-party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities.
Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998. You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies corrected.

5. Declarations

(i) 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

(ii) 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 my claim have been disclosed.

I/We understand that non-disclosure or misrepresentation of a material fact or matter will entitle the insurer to avoid this insurance.

Signature

Date

Please return this form to Patient Plan Direct Claims Partnership House Priory Park East Hull HU4 7DY

Tel: 01482 213 215 Email: ppd@insurance-partnership.com