

ORTHODONTIC AND SPACE MAINTAINER
CLAIM FORM

VhiDeCare
Dental



DeCareSM
International

Vhi
HEALTHCARE

How to Submit an Orthodontic or Space Maintainer Claim

1. Complete Section A and B of this claim form.
2. **Your Personal Bank Information must be included to ensure prompt claim reimbursement.**
3. You will need the assistance of your Orthodontist or Dentist to complete Section C and D of this claim form.
4. **When you pay the amount due, please obtain an itemised receipt from your Orthodontist or Dentist.**
5. Have the Orthodontist or Dentist sign and stamp the claim form.
6. Send the completed form and receipt(s) to:
Vhi DeCare Dental, IDA Business Park, Claremorris, Co. Mayo.

NOTE.

1. For any Claim Queries please contact Vhi DeCare Dental on **CallSave 1850 44 44 44.**
2. **All claims must be accompanied by an itemised receipt.**
3. Orthodontist or Dentist must sign and stamp the claim form.
4. Incomplete or illegible claim forms will be returned and not be processed. **This includes personal bank information.**
5. Claims must be submitted within 6 months of commencing treatment.
6. Waiting periods may apply. Please refer to Benefit Booklet.
7. Use the Vhi DeCare Orthodontic Claim Form for submitting claims for Orthodontic treatment and for Space Maintainers.

When active Orthodontic treatment has commenced and/or the appliance (Brace or Space Maintainer) has been fitted, submit a claim with the following information on the form:

- ✓ Tick appropriate procedure code
- ✓ Date active treatment commenced following fitting of appliance (for orthodontic work started prior to plan eligibility, benefits will be prorated)

- ✓ Estimated length of treatment in months
- ✓ Total treatment charge

A single payment of €1,000 will be made to the member following submission of a valid orthodontic claim.

A payment at the normal reimbursement level of 70% will be made for a Space Maintainer.

Explanation of Terminology

Space Maintainer –

A passive appliance, which may be fixed or removable designed to prevent tooth movement especially following the early loss of one or more baby (deciduous) teeth.

Limited Ortho Treatment –

Orthodontic treatment with a limited objective, not involving the entire dentition (all teeth in the mouth). Examples, of this type of treatment are, treatment in one arch only to correct crowding and partial treatment to open or close spaces.

Interceptive Ortho Treatment –

An Orthodontic procedure usually carried out in the mixed dentition (period when there are baby and adult teeth in the mouth) with the objective of lessening the severity of a developing problem. Examples of this type of treatment are, redirecting of a tooth that has failed to erupt and align properly into the dental arch (curved line of teeth in upper or bottom jaw), correction of a minor cross bite and recovery of recent minor loss of space.

Comprehensive (complete) Ortho Treatment –

Orthodontic Treatment carried out with the objective of improving dysfunction or deformity of the jaws. Treatment may involve more than one phase and usually involve the use of fixed appliances (braces).

**VhiDeCare
Dental**

POSTAL ADDRESS

Vhi DeCare Dental, IDA Business Park, Claremorris, Co. Mayo.

Telephone Number

CallSave 1850 44 44 44

Lines open: 8am - 8pm Monday - Friday
9am - 2pm Saturday

Fax Number

Dublin: (01) 799 4091
Website: www.vhi.ie/dental
E-mail: dental@vhi.ie

Orthodontic and Space Maintainer Claim Form

Please use the normal Vhi DeCare Dental Claim Form for all other dental claims.

Section A - Patient Details (Please use BLOCK CAPITALS)											
1. PATIENT NAME FIRST NAME		SURNAME		2. DATE OF BIRTH				3. GENDER			
				DD	MM	Y	Y	Y	Y	<input type="checkbox"/> Male <input type="checkbox"/> Female	
4. RELATIONSHIP TO POLICYHOLDER											
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify)											

Section B - Details of Policyholder (Please use BLOCK CAPITALS)														
5. FULL NAME			6. ADDRESS				7. DATE OF BIRTH							
							D	D	M	M	Y	Y	Y	Y
8. TOWN / URBAN AREA			9. COUNTY / CITY				10. VHI DECARE DENTAL POLICY NO.							
I declare that the expenses and details submitted with this form were incurred by me and/or members covered under the dental policy. I declare that to the best of my knowledge, the information contained on this form is true in every respect. I consent to Vhi Healthcare's and DeCare Dental Insurance Ireland Ltd.'s use of the information on this form for administration of my dental coverage. I understand that I am responsible for all costs of dental treatment.							11. SIGNED (Patient, or parent if under age 18)			12. DATE				
							X Signature:							

PERSONAL BANK INFORMATION		BANK NAME		BANK ADDRESS				SORT CODE					
ACCOUNT TYPE (Please Tick)										ACCOUNT NO.			
CURRENT <input type="checkbox"/>					SAVINGS <input type="checkbox"/>								

Section C - Billing Dentist (Please use BLOCK CAPITALS)							
13. NAME OF BILLING DENTIST OR DENTAL ENTITY			14. DENTIST STAMP				
15. ADDRESS							
16. TOWN / URBAN AREA		17. COUNTY / CITY					
18. DENTAL COUNCIL REGISTRATION NO.		19. TELEPHONE NO.		20. DENTIST SIGNATURE		21. DATE	
				X			

Orthodontic and Space Maintainer Claim Form

Section D - Claims Details (You will need assistance from your Orthodontist or your Dentist to complete this section.)
Use tooth numbering system normally used in dental practice.

Code	Description	Date Active Treatment Commenced	Estimated Length of Treatment in Months	€ Fee
Orthodontic Treatment Children 8 - 18 years				
8030	Limited Ortho Treatment			
8060	Limited Ortho Treatment			
8080	Comprehensive Ortho Treatment of the Adolescent Dentition			

Code	Description	Date Appliance Fitted	Missing Tooth Number(s)	€ Fee
Space Maintainers (Children)				
1510	Fixed Space Maintainer - unilateral			
1515	Fixed Space Maintainer - bilateral			
1520	Removable Space Maintainer - unilateral			
1525	Removable Space Maintainer - bilateral			

Other (List services not described above)				

Total Fee	€
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