



Dental Pre-Certification

Claim Form



Section 1: Policy Details - for completion by the Policy Holder/Member (Please place 'X' in required boxes)

1.1 Quote Policy No. Here:

1.2 Policy Holder's Name: _____

1.3 Policy Holder's Address: _____

1.4 Is this the Policy Holder's permanent address? Yes No

1.5 Patient's Name: _____

1.6 Patient's Date of Birth:

1.7 Contact Telephone No.: _____

1.8 Email Address: _____

Section 2: History of Illness - for completion by the Policy Holder/Member (Please place 'X' in required boxes)

2.1 Name of consultant/dental practitioner first attended: _____

2.2 Date of first consultation: 2.3 Consultant's/dental practitioner's address: _____

2.4 When was it first made known to you that this particular treatment (which is the subject of this claim) was required?

2.5 Has this patient had this or a similar illness before? Yes No 2.6 If Yes, please give date and details: Date:

Details: _____

2.7 Are any of these expenses fully or partially recoverable from any other source? Yes No 2.8 If Yes, please give details: _____

Section 3: Policy Holder/Member Authorisation

I declare that to the best of my knowledge, the foregoing statements are true in every respect. I authorise the consultant/dental practitioner/hospital to supply all necessary information to Vhi Healthcare, if requested, copies of my hospital/medical records. I also authorise Vhi Healthcare to pay appropriate benefits direct to the consultant(s)/dental practitioner(s)/hospital concerned. Vhi Healthcare may provide information to the hospital verifying my policy eligibility. Charges which are not eligible for benefit remain my responsibility to settle directly with the consultant(s)/dental practitioner(s)/hospital concerned.

X Policy Holder's/Member's Signature _____ Date:

(You must sign here)

Please check that you have entered your Policy Number

DATA PROTECTION NOTICE - The information you provide becomes part of the personal data held by Vhi Healthcare and is automated. It is used for the payment of claims and for the provision and administration of health insurance products and related services. Full details of the Vhi Healthcare's use of personal data appear in the public register held by the Data Protection Commissioner.

Section 4: Location of Treatment - for completion by the Consultant/Dental Practitioner (Please place 'X' in required boxes)

For completion by the consultant/dental practitioner who will carry out the proposed treatment. To be accompanied by radiographs of sufficient clarity and detail on which to base the proposed surgery. These procedures do not ordinarily require overnight hospitalisation. Benefit is generally payable only when carried out in the following locations:

4.1 Proposed location of treatment: Dentist's Surgery Out-patient Day Case Inpatient

4.2 Facility Name: _____

4.3 Facility Address: _____



Section 5: Dental Details - for completion by the Consultant/Dental Practitioner (Please place 'X' in required boxes)

5.1 Patient's Name: _____ 5.2 Consultant's/Dental Practitioner's Name: _____

5.3 Consultant's/Dental Practitioner's Address: _____

5.4 By whom was the patient referred to you? _____

5.5 Duration of symptoms:

HOURS	DAYS	WEEKS	MONTHS	YEARS
HH	DD	WW	MM	YY

 5.6 Date patient first consulted you with symptoms:

DD	MM	YY
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5.7 Please give details of previous episodes or related problems: _____

5.8 Description of examination, test, relevant findings and final diagnosis: _____

Section 6: Proposed Treatment - for completion by the Consultant/Dental Practitioner (Please place 'X' in required boxes)

6.1 Anticipated date of treatment:

DD	MM	YY
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 6.2 Procedure Code:

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6.3 Procedure Description: _____

6.4 Reason for treatment at this time: _____

6.5 If gingival and/or periodontal surgery is proposed, it is necessary to use the pocket depth chart for periodontal pocket depths of 6mm or more. The deepest pocket only should be recorded for each tooth when 6mm or more. **(N.B. Enclose relevant Radiographs)**

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Benefits only applies when pocket depth is 6mm or more

6.6 Indicate the reason for the method of anaesthetic (or sedation) to be employed apart from local anaesthesia: _____

6.7 If in exceptional circumstances, the patient is to be kept overnight, please indicate the reason: _____

6.8 Is any further oral/dental surgical treatment anticipated apart from the treatment described on this claim form? Yes No

6.9 If Yes, please give details: _____

6.10 Please confirm radiological evidence has been enclosed to support the proposed treatment: Yes No

Please append any further relevant details and/or a dental chart if appropriate for purposes of clarification.

Section 7: Consultant/Dental Practitioner Declaration

I hereby certify that the treatment specified was necessitated by the illness described by me above and was justified by the patient's medical condition.

X Consultant's/Dental Practitioner's Signature

(You must sign here)

Consultant/Dental Practitioner Code:

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Date:

DD	MM	YY
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Section 8: Dental Advisor - for completion by Vhi Healthcare's Dental Advisor (Please place 'X' in required boxes)

8.1 Is information consistent with x-ray? Yes No 8.2 Is proposed treatment appropriate for benefit? Yes No

8.3 Approved for Vhi Procedure Code(s):

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 8.4 Comments: _____

X Vhi Healthcare's Dental Advisor's Signature

(You must sign here)

Date:

DD	MM	YY
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Guidelines to making a Claim

It would help us give you a speedier service and keep down administration costs if you could observe these guidelines when submitting a claim.

Sections 1, 2 and 3 are to be completed and signed by the **Policy Holder or Insured Member**.

Sections 4, 5, 6 and 7 are to be completed and signed by the **Consultant/Dental Practitioner** who will carry out the proposed treatment.

Section 8 must be completed by **Vhi Healthcare's Dental Advisor**. The completed form with the radiological evidence should be submitted to Vhi Healthcare's Claims Department for assessment by our dental advisors. Please ensure that it is fully completed and that the Policy Number is shown.

The following procedures require prior approval:-

- | | |
|--|--|
| (a) Removal of buried tooth roots (single or multiple) | (c) Mandibular implants (osseointegrated implants) |
| (b) Removal of impacted or unerupted teeth | (d) Periodontal/gingival surgery |

N.B. When the account for treatment is submitted, the date on which treatment has been carried out should be clearly indicated on it.

Direct Payment of benefit towards professional fees to consultants/dental practitioners

Under the Finance Act, 1988, Vhi Healthcare is required to pay benefit in respect of consultants'/dental practitioners' fees direct to the consultant/dental practitioner concerned. We are also required to deduct Withholding Tax from these payments and remit it to the Revenue Commissioners. This does not, in any way, affect or reduce the value of your Vhi Healthcare cover.

As the costs of consultant/dental practitioner treatment vary, we advise you to obtain an estimate of all the likely professional fees before treatment begins.

Postal Address

IDA Business Park, Purcellsinch, Dublin Road, Kilkenny. Fax: (056) 776 1741

Dublin: Vhi House, Lower Abbey Street, Dublin 1. Fax: (01) 799 4091

Cork: Vhi House, 70 South Mall, Cork. Fax: (021) 427 7901

Dun Laoghaire: 35/36 Lower George's Street, Dun Laoghaire. Fax: (01) 619 7456

Galway: Vhi House, 10 Eyre Square, Galway. Fax: (091) 564 307

Limerick: Gardner House, Charlotte Quay, Limerick. Fax: (061) 310 361

Office opening hours: 9am-5pm Monday to Friday

Tel: CallSave 1850 44 44 44.
Lines open 8am-8pm Monday to Friday and 9am-2pm Saturday.

Website: www.vhi.ie **E-mail:** info@vhi.ie

