PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS USING BLACK INK

GLOBAL HEALTH
DENTAL CLAIM FORM

WILLIAM RUSSELL
Peace of mind wherever you are

PLEASE NOTE: General claims and claims for maternity treatment must be made on their own claim forms which are available at www.william-russell.com or by calling +44 1276 486455.

IMPORTANT – PLEASE READ THESE INSTRUCTIONS CAREFULLY.

SECTION A & B MUST BE COMPLETED BY THE PATIENT, OR BY THE PATIENT'S GUARDIAN OR LEGAL REPRESENTATIVE.

SECTION C MUST BE COMPLETED BY THE TREATING DENTIST. WE CANNOT SETTLE YOUR CLAIM UNLESS SECTION C IS FULLY COMPLETED BY THE DENTIST.

ALL CLAIMS MUST BE SUBMITTED WITHIN 6 MONTHS OF THE DATE OF THE FIRST CONSULTATION.

SECTION A – To be completed by the patient or the patient's guardian or legal representative

1. CLAIMANT DETAILS

Full name of Global Health policyholder: **Title: Mr/Mrs/Miss/Ms/Dr**

Full name of patient (if not the policyholder): **Date of birth:**

Global Health plan policy number: **Sex: ❑ Male ❑ Female**

Full mailing address:

Telephone: **Fax:** **Email:**

Please state the name and address of your personal physician (General Practitioner):

Name:

Address:

Telephone: **Fax:** **Email:**

2. COMPLETE THIS SECTION IF YOUR CLAIM IS FOR EMERGENCY DENTAL TREATMENT FOLLOWING AN ACCIDENT

On what date were you admitted to hospital: **On what date were you discharged form hospital:**

Please state the date of the accident:

Please give details of the accident:

Please give details of the damage suffered:

3. COMPLETE THIS SECTION IF YOUR CLAIM IS FOR ROUTINE DENTAL TREATMENT

Please state your reason for visiting the dentist:

SECTION B – Payment details and declaration

1. PLEASE LIST THE BILLS FOR WHICH YOU ARE SEEKING REIMBURSEMENT

Please attach the original, fully itemised accounts. We cannot accept copies.

Date(s) of treatment	Details of the bills you have enclosed for reimbursement	Please state currency and amount paid

2. PLEASE STATE HOW YOU WISH TO BE REIMBURSED

❑ **PAYMENT TO YOUR VISA CARD NB. We can only make payment to a visa card, and payment will be made in your plan currency.**

Card number: Name on card: Expiry Date:

Address to which card registered (if different from above):

❑ **PAYMENT TO YOUR BANK ACCOUNT**

Bank name and address:

Account holder name(s): Bank account number*:

Sort code: BIC Number*: IBAN number*:

* BIC and IBAN details are necessary for all transfers to European bank accounts.
* BIC and bank account number are necessary for all transfers to international bank accounts.

❑ **BANK DRAFT** Please state currency of bank draft:

3. DECLARATION AND AUTHORISATION AND CONSENT BY THE PATIENT OR HIS/HER LEGAL REPRESENTATIVE

Do you have any other health insurance cover? ❑ **No, I have no other health insurance cover**
❑ **Yes, I have other health insurance cover with:**

I hereby declare that, to the best of my knowledge and belief, all information provided in this claim form is accurate and complete. I hereby authorise any doctor of medicine, hospital or other person who has attended or examined me, to furnish to William Russell Ltd or to their authorised representative any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records relating to me (or to the patient if I am the patient's parent/legal guardian).

I hereby give William Russell Limited authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition/s and financial payment information.

Signature of Patient or guardian: **Date:**

SECTION C – To be completed by the patient's dentist

1. PATIENT DETAILS

Patient's full name: **Date of birth:**

Sex: ❑ **Male** ❑ **Female**

Was the patient referred to you? ❑ **YES** ❑ **NO**

If YES, please state the name and contact details of the referring doctor:

For how long have you known this patient?

2. IF YOUR PATIENT'S CLAIM IS FOR ROUTINE DENTAL TREATMENT

Please state their reason for visiting the dentist:

3 a. IF YOUR PATIENT'S CLAIM IS FOR EMERGENCY DENTAL TREATMENT FOLLOWING AN ACCIDENT

On what date did the accident occur? **On what date did the patient first consult you?**

On what date was the patient admitted to hospital? **On what date was your patient discharged from hospital?**

Was the hospitalisation on: ❑ **an in-patient basis** ❑ **a day-patient basis**

Are the patient's injuries related to any previous injury? ❑ **YES** ❑ **NO**

If the answer to this question is YES, please give full details of the previous injury:

Has there been any damage to existing crowns, bridges or artificial teeth? ❑ **YES** ❑ **NO**

If the answer to this question is YES, please give full details:

b. PLEASE GIVE FULL DETAILS OF THE TREATMENT YOUR PATIENT HAS RECEIVED

Please state diagnostic tests performed and your reason for the tests

Tests performed	Reason for tests

Please give full details of the treatment your patient has received

Dates	Treatment performed

4. DECLARATION BY DENTIST

I declare that I am the patient's treating Dentist, and that the particulars given above are, to the best of my knowledge, full, true and complete.

Signature: **Date:**

Please print your name and address:

Contact telephone number: **Fax:** **Email:**

Qualifications:

PLEASE VALIDATE THIS INFORMATION WITH YOUR STAMP

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