



Chester House
 Harlands Road
 Haywards Heath
 West Sussex RH16 1LR
 Telephone: +44 (0)1444 444957
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DENTAL INSURANCE CLAIM FORM

IMPORTANT: Please complete form in full, failure to do so may delay payment of claim. Proof of claim must be submitted within 90 days of first of incident. In order for your dental claim to be considered for reimbursement, you must complete and sign this claim form. Please mail or fax this completed claim form with itemized bills and receipts to the address or fax listed above. When mailing, please tape small receipts to a letter or A4 paper. Please do not staple receipts to claim form.

Documents and signed claim forms can be scanned and emailed to: healthcare@lampinsurance.com

SECTION A: Member and Patient Information

Certificate Number: _____	Policy Holder: _____
Policy Holder's D.O.B: _____ (dd/mm/yyyy)	Street Address: _____
Mailing Address: _____	State/Province: _____
City: _____ Postal/Zip Code: _____	Country: _____
Patient's Name: _____	Patient's D.O.B: _____ (dd/mm/yyyy)
Email Address: _____	Patient's relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Child <input type="checkbox"/> Other

SECTION B: Claim Information

REIMBURSEMENT: Payments are made in USD dollars unless other currency is requested and are subject to USD Exchange Rate of date service rendered.

ASSIGNMENT OF BENEFITS: Yes No (Yes, for direct payment to dental practitioner or hospital)
 I hereby authorise payment to the dental practitioner or hospital as indicated on receipts. I understand that I am financially responsible for charges not covered by the policy. Payment will be made by Wire Transfer.

Please note your bank or other intermediary bank may assess a fee for the receipt of a wire transfer and that these fees are not reimbursable under this plan.

Please note that wire transfer may also be processed in other currencies, to request a different currency

please indicate: _____

Beneficiary Name(s) (as it appears on the account): _____	
Bank Account No: _____	Bank Name: _____
Bank Address: _____	
Bank Tel. No: _____	Swift Code/BIC: _____
Account Currency: _____	IBAN#: _____

SECTION C: Policy holder or authorized person's Signature and Release

(Parent or Guardian, if claim is for minor). I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading or incomplete information. I authorise the release of all records or other information that may be necessary to determine benefits payable.

POLICY HOLDER OR AUTHORISED SIGNATURE: _____ DATE: _____ (dd/mm/yyyy)



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SECTION D: To be completed by Attending Dentist

Dentist's Name: _____ Street Address: _____
 City: _____ Postal/Zip Code: _____ State/Province: _____
 Society or T.I.N. (if applicable): _____ Country: _____
 Licence (if applicable): _____ Telephone No: _____
 First visit date, current series: _____ (dd/mm/yyyy)

TREATMENT DETAILS

Please tick one. This is a statement of: **ACTUAL** charges This is a **Pre-treatment ESTIMATE** of charges

1. Is treatment a result of: Occupation Illness Accident Other

Please give details: _____

2. Are any of these services covered by any other plan? Yes No

If yes, please give details: Name of Provider: _____ Policy Holder Name/Number: _____

3. Are Radiographs or models enclosed? Yes No

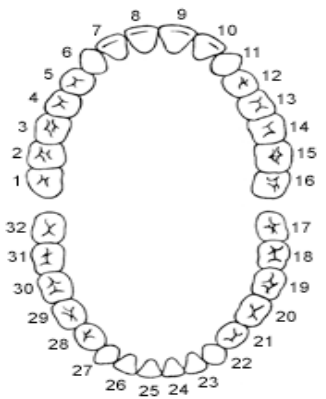
4. If prosthesis or crowns, is this initial replacement? Yes No

If no, give date of prior placement: _____ (dd/mm/yyyy)

5. Is the treatment for Orthodontics? Yes No Months Remaining: _____

If services already commenced enter date appliances placed: _____ (dd/mm/yyyy)

Fig. 1



Notes for Fig. 1:

- Examination details to be completed
- Identify missing teeth with "X" on the dental plan
- If services cannot be completed within 90 days from the date of examination, the patient must obtain a new authorisation and claim form for uncompleted services
- A pre-operative x-ray of root canal work is required
- Post operative bite-wing x-rays must be provided when requested by LAMP Insurance Company Limited.

EXAMINATION AND TREATMENT PLAN

(Description of service should include x-rays, prophylaxis, materials used etc.)
 List in order from tooth No. 1 through to No. 32, using chart system shown

Tooth ref	Surface	Description of Service Line No.	Date of Service	Procedure No.	Fee	Office use only
		1				
		2				
		3				
		4				
		5				

DENTIST'S CERTIFICATION FOR SERVICES PROVIDED

I am a specialist in: Orthodontics Endodontics Oral Surgery Peridontics Other _____

Total amount for services provided: _____ (State currency if not US\$)

Has payment been received? Yes No

I certify the items listed above were provided and completed by my practice. Total No. _____

DENTIST SIGNATURE _____ Date: _____ (dd/mm/yyyy)

DENTAL DETERMINATION: Covered expenses on "Carrier pays" are authorized. Payment will be made provided the treatment is performed while the patient is covered. Payment will be made subject to all limitations and maximums.