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Find out more at [www.cigna.co.uk/healthydiscounts](http://www.cigna.co.uk/healthydiscounts)

Name of member:

Date of birth:

Name of patient:

Date of birth:

Cigna ID number:

Name of employer/group scheme:

## 1. PATIENT'S DETAILS To be completed by patient. Please complete in BLOCK CAPITALS.

Address			
Town/city			
County		Postcode	
Telephone no.		Relationship to member	
Email address			
Claim settlement (please carefully read note 2 below before completing this section)			
Name of account holder(s)			
Branch sort code		Bank account no.	

### IMPORTANT NOTES - PLEASE READ CAREFULLY

- Please complete this form for regular dental claims. Please complete the OralHealth (non-routine treatments) claim form for unexpected oral health problems including dental emergencies, oral cancer, hospital cash benefit and accidental damage. Complete the relevant sections as fully as possible as failure to do so could delay settlement of the claim.
- Please consider giving us your bank account details as a direct payment to your account will improve our claims turnaround service to you. If you wish payment made directly into your bank account, you must enter your bank details on every claim form you send us (otherwise we will pay you by cheque). All bank details you provide Cigna with will be kept secure and will only be used to pay your claim.
- After treatment is complete, ensure that you and a qualified staff member at the dentist/specialist/hospital sign the relevant sections of this form.
- Settle the bill direct with your dentist and remember to obtain a full payment receipt.  
It is advisable to retain copies or details of all bills or receipts submitted for your own reference.
- Then forward the completed claim form, along with the original receipts to: Cigna Dental Claims, 1 Knowe Road, Greenock, Scotland PA15 4RJ**  
Alternatively, please scan both sides of the claim form along with the corresponding receipts and email to [smyle@cigna.com](mailto:smyle@cigna.com).  
We reserve the right to request the original copies so please do not destroy these whilst the claim is being processed.

## 2. DECLARATION AND AUTHORISATION TO RELEASE DENTAL INFORMATION

I confirm that the treatment was carried out under N.H.S./privately (please delete as appropriate) and I hereby declare that the statements on this form are true and accurate. I hereby authorise any Dentist, Pharmacy or Insurance Company to release any information regarding the dental history, treatment or benefits payable for this claim to Cigna for the purpose of validating and determining benefits payable in connection with this claim. This authorisation or photostat copy of the original shall be valid for one year from the date of signature. Data may be extracted for statistical audit and verification purposes. I understand that I may request a copy of this authorisation.

**Access to Medical Reports Act 1988** - Before your dentist can complete the form, you must give your consent. Before you give your consent you should be aware of your rights under the Act, which are summarised as follows:

- You may withhold your consent.
- You may see the report before it is sent to us within 21 days from the date of the report.
- You may ask to see the report for up to 6 months after the report is completed.
- You may ask the dentist to amend any part of the report, which you consider to be incorrect or misleading. If he does not agree with your request, you may attach your comments to the report.

NB: The dentist may withhold all or any part of the report from you if he considers that you may be physically or mentally harmed by it. Having been made aware of my rights under the Access to Medical Reports Act 1988 in connection with my claim:

- I hereby consent to Cigna seeking a medical report from my dentist as to the history and nature of the condition or its treatment. This consent only applies to the condition for which I am making a claim.
- I DO/ DO NOT wish to see the report before it is sent to Cigna (delete as required).
- I authorise the dentist to disclose such information to Cigna.

Data Protection Act 1998 - We need your explicit approval to process your data as some of the information contained in the claim may be classified as sensitive data under the Act. Please confirm your agreement by signing below.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(or parent/guardian if under 18)

THIS SECTION TO BE COMPLETED BY A  
QUALIFIED STAFF MEMBER AT THE DENTAL PRACTICE.

## NHS TREATMENT

		Date of treatment	Charge to patient
Band 1	BD1DN		
Band 2	BD2DN		
Band 3	BD3DN		
Band 4	BD4DN		

## PREVENTATIVE TREATMENT

Code	Treatment	No of units	Tooth	Date of treatment	Charge to patient
<b>EXAMINATIONS</b>					
A01	Normal				
A11	Extensive				
A21	Full Case Assessment				
<b>X-RAYS</b>					
B01	Bitewing				
B02	Intra Oral				
B03	O.P.G.				
<b>SCALING AND POLISHING</b>					
E01	One Visit				
<b>MISCELLANEOUS TREATMENT</b>					
D01	Fissure Sealants				
D11	Topical Fluoride Application				
M0U	Occlusal Splint				

## MINOR TREATMENT

Code	Treatment	No of units	Tooth	Date of treatment	Charge to patient
<b>FILLINGS</b>					
G01	Amalgam-One Surface				
G02	Amalgam-Two+Surfaces				
G03	Amalgam-Three+Surfaces				
G21	Composite Anterior-One Surface				
G22	Composite Anterior-Two+Surfaces				
G23	Composite Posterior-One Surface				
G24	Composite Posterior-Two+Surfaces				
G31	Additional charge use of pin				
<b>ROOT CANAL TREATMENT</b>					
H01	Upper & Lower Anterior (1 root)				
H02	Upper Premolar (2 roots)				
H03	Lower Premolar (1 root)				
H04	Molars (3 + roots)				
<b>EXTRACTIONS</b>					
L01	Single				
L02	Per additional tooth				
N11	Post Operative Care				
<b>SURGICAL PROCEDURES</b>					
M01	Extraction/Removal Bone Debris				
M02	Extraction - soft tissue involved				
H21	Apicectomy				
<b>ANAESTHETICS</b>					
W11	Relative Analgesia/Nitrous Oxide				
P42	I.V. Valium				
<b>OCCASIONAL TREATMENT</b>					
S01	Dressings				
S11	Incising an Abscess				
S21	Open Root Canal for Drainage				
T11	Recementing Crowns/Bridges				
U01	Abnormal Haemorrhaging				

A 3x15 grid of squares. The middle row contains numbers 8, 7, 6, 5, 4, 3, 2, 1, 1, 2, 3, 4, 5, 6, 7, 8 from left to right. The top and bottom rows contain diamond shapes in the 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th, 14th, and 15th columns. The 1st and 16th columns are empty in the top and bottom rows.

## MAJOR TREATMENT

Code	Treatment	No of units	Tooth	Date of treatment	Charge to patient
<b>PERIODONTAL TREATMENT (NON SURGICAL)</b>					
E21	Prolonged (Curettage/Root Planing)				
F51	Splinting				
<b>PERIODONTAL TREATMENT (SURGICAL)</b>					
F01	Gingivectomy				
F11	Mucoperio, Flap Bone Surgery				
<b>DENTURES - ACRYLIC</b>					
Q31	Partial or Full Upper OR Lower				
Q32	Partial or Full Upper AND Lower				
<b>DENTURES - METAL</b>					
Q43	Partial				
Q41	Full Upper or Lower				
<b>DENTURES - METAL/ACRYLIC</b>					
R63	Additional Tooth				
R61	Addition of Clasp				
K71	Denture Repair				
<b>CROWNS/BRIDGES</b>					
J01	Veneers (per tooth)				
K32	Adhesive Bridges				
K41	Conventional Bridgework				
K12	Standard Post & Core				
K11	Gold Post & Core				
K07	Bonded Precious Crown				
K05	Bonded Non Precious Crown				
K08	Full Cast Crown				
K06	Full Porcelain Crown				
<b>INLAYS</b>					
K02	Precious				
K01	Non Precious				
K03	Porcelain				
<b>IMPLANTS</b>					
IM	Dental Implant				
<b>ADDITIONAL INFORMATION</b>					

## UK & OVERSEAS EMERGENCY COVER

Code	Treatment	No of units	Tooth number	Date of treatment	Charge to patient
	Accident				
	Emergency				

**Total**

I confirm that the treatment has been/will be carried out under the N.H.S./privately and I hereby declare that all treatment and charges as stated are being submitted for approval/have been completed.

Signature (qualified staff member):

Date:

Dentist's stamp