CLAIM FORM - OralHealth (non routine treatments)

Download your next claim form from your member portal at www.cigna.co.uk/members or visit the Members page at www.cigna.co.uk

Find out more at 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

1 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.

2 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.

3 After treatment is complete, ensure that you and a qualified staff member at the dentist/specialist/hospital sign the relevant sections of this form.

4 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.

5 **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.
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:

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of the report.
3. You may ask to see the report for up to 6 months after the report is completed.
4. 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:

1. 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.
2. I DO/ DO NOT wish to see the report before it is sent to Cigna (delete as required).
3. 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)

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3. EMERGENCY TREATMENT

To be completed by the patient. Brief description of circumstances requiring emergency treatment stating whether the treatment received was for the relief of swelling, bleeding or pain.

(continue on a separate sheet if necessary)

Where did you receive your treatment? *(Please attach the relevant receipt)*	Own dentist	◯	Other dentist	◯

Description of emergency treatment provided?

Date	Treatment carried out	Cost

4. TREATMENT ARISING FROM AN ACCIDENT (CONTACT CIGNA WITHIN 14 DAYS OF THE ACCIDENT - 01475 492351)

To be completed by the patient. Description of the accident and injury (continue on a separate sheet if necessary). Please note we may need to see photographs of the injury as evidence of trauma and also any official accident reports e.g. police, employer, ambulance.

To be completed by the dentist. Details of treatment provided. Please note that all treatment relating to the accident (other than emergency palliative treatment) must be pre-authorised by Cigna. A treatment plan and x-rays must be submitted to us prior to the start of the treatment. We may also request study models.

Date	Treatment carried out	Cost

5. ORAL CANCER (CONTACT CIGNA ON 01475 492351 FOR PRE-AUTHORISATION)

To be completed by the specialist. (Please attach report of definitive histopathological diagnosis following biopsy)

Date of initial consultation:		Date oral cancer diagnonsis confirmed:	

Specialist details

Name:		Telephone number:	
Address:			

6. ORTHODONTIC TREATMENT

Date:	
Treatment carried out:	
Total time span of treatment:	

7. IMPLANTS (CONTACT CIGNA ON 01475 492351 FOR PRE-AUTHORISATION)

All treatment must be pre-authorised by Cigna. A treatment plan and x-rays must be submitted to us prior to the start of the treatment

Date	Treatment carried out	Cost

Patient signature:		Dentist stamp
Date:		
Dentist's signature:		
Telephone number:		
Date:		