Chester House
Harlands Road
Haywards Heath
West Sussex RH16 1LR
Telephone: +44 (0)1444 444957
Facsimile: +44 (0)1444 450872

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: ☐ Self ☐ Spouse ☐ Child ☐ Other

Gender: ☐ Male ☐ Female

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

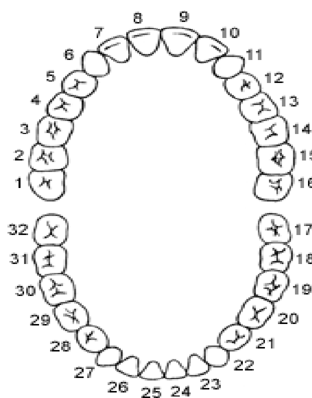
4. If prosthesis or crowns, is this initial replacement? ☐ Yes ☐ No

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.

LAMP Insurance Company Limited – registered in Gibraltar – company number 93562. LAMP Services Limited – registered in England and Wales – company number 04967967
UK REGISTERED OFFICE / OPERATING ADDRESS: Chester House, Harlands Road, Haywards Heath, RH16 1LR
GIBRALTAR REGISTERED OFFICE ADDRESS: 260/262 Main Street Gibraltar OPERATING ADDRESS: 260/262 Main Street Gibraltar
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