CIGNA Dental Care
Claim Form

Name of Member

Date of Birth

Name of Patient

Date of Birth

Member's No.

Name of Employer/Group Scheme

1. Patient's Details

To be completed by patient. Please complete in BLOCK CAPITALS.

Address

Postcode:

Telephone No.

Relationship to Member:

Important Notes - Please read carefully

1 Please complete this form fully, as failure to do so could delay settlement of the claim.

2 After treatment is complete, ensure that the dentist completes the reverse side of this form, outlining the treatment received.

3 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.

4 **Then forward the completed claim form, along with the *original* receipts to: CIGNA Dental Claims, 1 Knowe Road, Greenock, Scotland PA15 4RJ**

5 **Please note that prior approval from CIGNA must be sought for all major treatment before any of the treatment commences**
(This includes periodontal treatment, dentures, crowns, bridges, veneers & inlays).
The claim form should then be forwarded to CIGNA with the relevant X-rays and/or study models, which are available from your dentist.

6 If claiming for accident or emergency treatment, please provide full details.

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 and confirm that the statements on this form are true and complete. 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.

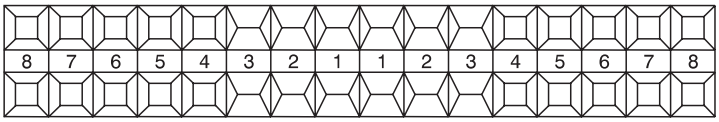
Signature of Patient: ..... Date: .....
(or Parent/Guardian if under 18)

CIGNA HealthCare
CIGNA Dental Care, 1 Knowe Road, Greenock, Scotland PA15 4RJ

THIS SECTION TO BE COMPLETED BY THE DENTIST

Is this form being submitted for approval? Yes ☐ No ☐

Are X-Rays and/or Study Models being enclosed? Yes ☐ No ☐



PREVENTATIVE TREATMENT

CODE	TREATMENT	NO OF UNITS	TOOTH NUMBER	DATE OF TREATMENT	CHARGE TO PATIENT
	EXAMINATIONS				
A01	Normal				
A11	Extensive				
A21	Full Case Assessment				
	X-RAYS				
B01	Bitewing				
B02	Intra Oral				
B03	O.P.G.				
	SCALING AND POLISHING				
E01	One Visit				
	MISCELLANEOUS TREATMENT				
D01	Fissure Sealants				
D11	Topical Fluoride Application				
M0U	Occlusal Splint				

MINOR TREATMENT

CODE	TREATMENT	NO OF UNITS	TOOTH NUMBER	DATE OF TREATMENT	CHARGE TO PATIENT
	FILLINGS				
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				
	ROOT CANAL TREATMENT				
H01	Upper & Lower Anterior (1 root)				
H02	Upper Premolar (2 roots)				
H03	Lower Premolar (1 root)				
H04	Molars (3 + roots)				
	EXTRACTIONS				
L01	Single				
L02	Per additional tooth				
N11	Post Operative Care				
	SURGICAL PROCEDURES				
M01	Extraction/Removal Bone Debris				
M02	Extraction - soft tissue involved				
H21	Apicectomy				
	ANAESTHETICS				
W11	Relative Analgesia/Nitrous Oxide				
P42	I.V. Valium				
	OCCASIONAL TREATMENT				
S01	Dressings				
S11	Incising an Abcess				
S21	Open Root Canal for Drainage				
T11	Recementing Crowns/Bridges				
U01	Abnormal Haemorrhaging				

MAJOR TREATMENT

CODE	TREATMENT	NO OF UNITS	TOOTH NUMBER	DATE OF TREATMENT	CHARGE TO PATIENT
	PERIODONTAL TREATMENT (Non Surgical)				
E21	Prolonged (Curettage/Root Planing)				
F51	Splinting				
	PERIODONTAL TREATMENT (Surgical)				
F01	Gingivectomy				
F11	Mucoperio, Flap Bone Surgery				
	DENTURES - ACRYLIC				
Q31	Partial or Full Upper OR Lower				
Q32	Partial or Full Upper AND Lower				
	DENTURES - METAL				
Q43	Partial				
Q41	Full Upper or Lower				
	DENTURES - METAL/ACRYLIC				
R63	Additional Tooth				
R61	Addition of Clasp				
K71	Denture Repair				
	CROWNS/BRIDGES				
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				
	INLAYS				
K02	Precious				
K01	Non Precious				
K03	Porcelain				
	ADDITIONAL INFORMATION				

UK & OVERSEAS EMERGENCY COVER

CODE	TREATMENT	NO OF UNITS	TOOTH NUMBER	DATE OF TREATMENT	CHARGE TO PATIENT
AEG	Accident				
OAE	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.

Dentist's Signature :

Date :

Dentist's Stamp