

# Claim form

# NDP

National  
Dental  
Plan

Part of Capita plc

## You complete this page

Simply fill in your personal details below and ask your dentist or receptionist to complete and stamp the reverse. Attach a receipt for the full cost of treatment. Alternatively; you may attach an itemised receipt to your claim form which includes all of the requested information on the reverse of the form. *Please note that we can only process claim forms that are accompanied by full proof of payment.*

Finally, post or scan your completed claim form and receipt(s) to Claims Assistance (UK) Ltd, Ibex House, Minorities, London EC3N 1DY or email [claim@nationaldental.co.uk](mailto:claim@nationaldental.co.uk) Tel: 020 7488 9880 (calls may be recorded for training and monitoring purposes).

### Please note:

Claims must be submitted within 90 days of completion of your last treatment in any course.

Reimbursement will be made in accordance with your benefit schedule.

Mr Mrs Miss Dr Other: ..... Date of birth: ..... / ..... / .....

Full name: .....

Home address (including postcode): .....

.....

.....

Name of employer: .....

NDP membership number (if known): .....

### PATIENT DETAILS (if different from above)

Mr Mrs Miss Dr Other: ..... Date of birth: ..... / ..... / .....

Full name: .....

### DECLARATION – to be signed by Patient (or by Member if Patient is under 18 years of age)

*I declare that the information provided on this form is, to the best of my knowledge, true and complete and authorise NDP to obtain any information relating to this claim from my dentist. I confirm that I give consent within the provisions of the Data Protection Act 1998 for NDP or its agent to process my personal data, including medical information, for the purposes of administering the dental plan.*

Telephone number: .....

Date: .....

Signature:

### PAYMENT

If you wish to receive payment by cheque, please tick here

If you wish to receive payment by BACS, please tick here  then complete details below.

Account name: ..... Account number: .....

Sort code: ..... Roll number (if applicable): .....

Email address for remittance advice: .....

# Your Dentist completes this page

Tel number:

Is the treatment as a result of an accident/sports injury? Yes / No

Treatment (Charged individually)	Date of treatment	Units of treatment	Charge	For internal use only
<b>NHS TREATMENT CHARGED BY BAND</b>				
NHS Band 1			£	
NHS Band 2			£	
NHS Band 3			£	
Emergency treatment			£	
<b>Preventative treatment</b>	<b>EXAMINATIONS*</b>			
	Basic examination		£	
	Extensive examination		£	
	Full case/New patient assessment		£	
	<b>X-RAYS*</b>			
	Small x-ray		£	
	Medium x-ray		£	
	Panoral x-ray		£	
	<b>SCALINGS*</b>			
	Simple scaling		£	
Hygienist		£		
<b>Minor treatment</b>	<b>FILLINGS</b>			
	Silver filling – 1 surface		£	
	Silver filling – 2 surfaces		£	
	Silver filling – 3 surfaces or more		£	
	White filling – 1 surface		£	
	White filling – 2 surfaces		£	
	White filling – 3 surfaces or more		£	
	Pin for filling		£	
	<b>ROOT TREATMENTS</b>			
	Incisor/Canine – No. of roots treated: <input type="text"/>		£	
	Premolar – No. of roots treated: <input type="text"/>		£	
	Molar – No. of roots treated: <input type="text"/>		£	
	Apicectomy		£	
	<b>EXTRACTIONS</b>			
	Extraction		£	
	Surgical extraction		£	
	<b>Major treatment</b>	<b>VENEERS AND INLAYS</b>		
Veneer <small>(Prior approval required before treatment if more than 1 per policy year)</small>			£	
Inlay			£	
<b>CROWNS, BRIDGES AND IMPLANTS</b>				
Crown			£	
Post for crown			£	
Conventional bridge*			£	
Adhesive bridge*			£	
Re-fix, re-cement crown or bridge			£	
Implant*			£	
<b>DENTURES</b>				
Acrylic upper or lower denture			£	
Acrylic upper and lower denture			£	
Chrome upper or lower denture			£	
Chrome upper and lower denture		£		
Repair or reline denture		£		
<b>MISCELLANEOUS</b>				
Anaesthetic*			£	
Orthodontics (children only)*			£	
Mouthguard (including sports guards)			£	
Emergency charges*			£	
Overnight hospital stay*			£	
Other treatments (please specify):			£	
<b>TOTAL CHARGE</b>			£	

**Dentist's stamp**  
(Required for processing)

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\*Restrictions apply. Please refer to your full benefit schedule for your plan specific entitlements.