INSTRUCTIONS FOR SUBMITTING CLAIMS – PLEASE READ CAREFULLY

Please ensure that ALL sections of this claim form are completed in BLOCK CAPITALS.

A new claim form must be completed for each insured person. You should complete and sign SECTION A. Your dentist or an authorised member of the dental practice should complete and sign SECTIONS B and C as appropriate.

Please note that under the PRSI dental scheme you may be entitled to a FREE annual examination in Ireland, this will not affect your claims limits, please check with your dentist if you are eligible before completing the claim form.

Benefits are remitted according to your table of benefits. This can be downloaded at www.vhi.ie/downloads

OVERSEAS COVER

If you require treatment whilst abroad, please obtain a detailed receipt in english and submit this with your claim form. Reimbursements will be related to your selected level of cover and the individual benefits listed. Settlements will be made in euro.

Please note: we are only able to accept receipts that have been translated into english, so you must arrange for this to be done before submitting them to us. You are responsible for the cost of any translation.

ACCIDENT OR SPORTS INJURY

If you need dental treatment following an accident or a sports injury, you must inform the claims administrator within 7 days of the accident or as soon as reasonably possible. Please provide full details of the circumstances regarding the accident or injury.

HOW TO MAKE A CLAIM

1. Complete SECTION A of this form and bring it with you when you go to the dentist
2. Once the treatment has been carried out, please get your dentist or an authorised member of the practice to complete SECTION B and C of this form. Please ensure SECTION B and C are fully itemised showing all treatments received and signed as appropriate
3. Settle the bill with your dentist and get a receipt
4. Send the fully completed claim form (1 form per patient) – together with the original payment receipts to Vhi Dental Claims
5. Your claim will be paid into your bank account within 10 working days

Please ensure that completed claim forms reach us within 180 days of completion of each item of treatment. Please note that benefits will NOT be paid in respect of claims which arrive beyond this period.

Note: If your dentist is in the Vhi Dental Network, you can avail of Dentist Direct Pay. You still need to complete SECTION A of this Claim form. You will only need to pay the dentist for any costs not covered by your policy. Your dentist will submit the claim and will be reimbursed directly by us. If you wish to avail of Dentist Direct Pay you must phone Vhi Dental before you attend the dentist. For more details visit www.vhi.ie/dental

IMPORTANT

Your policy number must be included, the tooth numbers must be entered where applicable and the dentist must be identified by his/her IDC/GDC number on the claim form.

If you have questions about your claim, call our DENTAL CLAIMS HELPLINE on 046 9077 337 from 8:30am - 6pm, Monday to Friday, 9am - 2pm, Saturday. Our experienced staff will be happy to help.

CLAIM CHECK LIST

Please ensure you have:
- Filled in and signed section A
- Entered your bank details
- Your dentist has filled in section B with relevant costs
- Attached all receipts
- Section C is complete with dentist IDC/GDC number
- The dentist has stamped and signed the form

CLAIMS ADMINISTRATOR

Vhi Dental Claims, Intana,
Collinson Insurance Solutions Europe Limited,
IDA Business Park, Navan, Co. Meath
Phone: 046 90 77337
email: vhidentalclaims@intana-assist.com
## SECTION A  INSURED DETAILS: TO BE FILLED IN BY MEMBER

<table>
<thead>
<tr>
<th>Name of policyholder</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of member</td>
<td></td>
</tr>
<tr>
<td>Policy number</td>
<td>Member date of birth</td>
</tr>
</tbody>
</table>
| Payment to | Dentist ☐ If dentist, bank details are not required on this form  
Member ☐ If member, please enter bank details below |
| Total claimed | € |
| IBAN |  |
| BIC |  |
| Member address |  |
| Email |  |
| Do you wish to receive settlement details by email? | Yes ☐ No ☐ |

**Contact numbers**

<table>
<thead>
<tr>
<th>Home</th>
<th>Mobile</th>
</tr>
</thead>
</table>

**Was this treatment received as a result of an emergency abroad or following an accident?**

If yes, please provide full details on a separate sheet.

[Yes ☐ No ☐]

**Does the claimant hold dental insurance or any form of dental or medical insurance with any other provider?**

If yes, please provide details below:

- **Provider:**
- **Policy number:**

---

**DATA PROTECTION STATEMENT**

In order to adjudicate on your claim, Vhi and Intana will process the personal data you have provided on this form, together with any personal data that you have authorised third parties to provide to us. Certain processing of your personal data is required in order for us to adjudicate on your claim and for us to be able to operate the business of providing dental insurance policies.

Vhi Healthcare DAC of Vhi House, Lower Abbey Street, Dublin 1 ("Vhi"), and Collinson Insurance Solutions Europe Limited trading as Intana, of IDA Business Park, Athlumney, Navan, County Meath ("Intana"), and the Insurer are the companies that control and are responsible for processing the personal data in relation to your claim. We will process your personal data in accordance with the Vhi Data Protection Statement which has previously been provided to you. If you would like another copy of the Vhi Data Protection Statement it is available at Vhi.ie, or you can request a copy by calling us on (056) 444 4444 or 1890 44 44 44.

**OBTAINING ADDITIONAL INFORMATION:**

In order to process and to establish the eligibility and appropriateness of your claim we will, as appropriate:

- Contact the facility and your treating practitioners (including, where relevant, your GP) on your behalf to request a copy of all necessary information including, if requested, copies of the facility/medical records relating to the treatment and/or services received by you as part of this claim.
- Approach any third party who holds information relating to the incident giving rise to this claim and obtain from them such information as is required to assist in the investigation and resolution of this claim.
- Share information with other insurers or financial institutions for the purposes of dealing with this claim and eliminating insurance fraud.

Where it is necessary, we will ask you to allow the treating practitioners to share your information with us.

**DECLARATION:**

I declare that the information completed above at the time of signing this declaration is true in every respect.

I authorise Intana on behalf of the Insurer to pay the appropriate benefits, for services provided, to the treatment facility and medical practitioners concerned. I understand that the details of these amounts will be included in my settlement statement and I will contact Intana directly with any queries. Charges which are not eligible for benefit will remain my responsibility to settle directly with the treatment facility/medical practitioner concerned.

---

**IMPORTANT – YOU MUST SIGN HERE:**

<table>
<thead>
<tr>
<th>Patient’s (or Parent/Legal Guardian if patient is under 18 years)* Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

*For claims in relation to a dependant under 18 years at the time of signing this form, please note that all correspondence and relevant payments will be made to the policyholder.*

Please check that you have entered your Policy Number.

Please note that the address you provide is purely for data validation purposes. If you need to update your contact details or membership/personal data, please contact our Customer Services Helpline at (056) 444 4444 or 1890 44 44 44.

**CHECK LIST:**

If all requested information is not supplied we will not be able to process your claim.

**Before submitting your claim please ensure:**

- All relevant documentation outlined on page 1 has been submitted with this claim.
- All supporting documentation are originals (we recommend that you retain copies).
- This claim form has been fully completed and signed.
## SECTION B  CLAIM DETAILS: TO BE FILLED IN BY A DENTIST OR AUTHORISED MEMBER OF THE PRACTICE

### INVESTIGATION AND PREVENTATIVE TREATMENTS

<table>
<thead>
<tr>
<th>Code</th>
<th>Treatment</th>
<th>Qty</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>120</td>
<td>Examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>150</td>
<td>Extensive examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>180</td>
<td>Periodontal examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>230</td>
<td>X-rays small (each)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>272</td>
<td>X-rays bitewing series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>330</td>
<td>X-rays panoramic or complete series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>240</td>
<td>X-rays occlusal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1110</td>
<td>Scale &amp; polish</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EMERGENCY TREATMENT (OUT OF HOURS)

<table>
<thead>
<tr>
<th>Code</th>
<th>Treatment</th>
<th>Tooth no. required</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>9110</td>
<td>Treatment of dental pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2940</td>
<td>Protective restoration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9630</td>
<td>Prescriptions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BASIC TREATMENTS: FILLINGS & SEALANTS

<table>
<thead>
<tr>
<th>Code</th>
<th>Treatment</th>
<th>Tooth no. required</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1351</td>
<td>Fissure sealant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2140</td>
<td>Silver filling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2150</td>
<td>Silver filling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2160</td>
<td>Stainless steel crown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2161</td>
<td>White filling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2391</td>
<td>Stainless steel crown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2392</td>
<td>White filling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2393</td>
<td>White filling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2394</td>
<td>White filling</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BASIC TREATMENTS: PERIODONTAL

<table>
<thead>
<tr>
<th>Code</th>
<th>Treatment</th>
<th>Tooth no. required</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>4341</td>
<td>Perio scaling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4910</td>
<td>Perio maintenance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4355</td>
<td>Full mouth debridement</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BASIC TREATMENTS: EXTRACTIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Treatment</th>
<th>Tooth no. required</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>7140</td>
<td>Tooth extraction (general practice)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7210</td>
<td>Surgical extraction (specialist)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BASIC TREATMENTS: CROWNS

<table>
<thead>
<tr>
<th>Code</th>
<th>Treatment</th>
<th>Tooth no. required</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>2930</td>
<td>Stainless steel crown</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MAJOR TREATMENTS: CROWNS, INLAYS AND ONLAYS

<table>
<thead>
<tr>
<th>Code</th>
<th>Treatment</th>
<th>Tooth no. required</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D025</td>
<td>Onlay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D126</td>
<td>Inlay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2752</td>
<td>Porcelain crown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2952</td>
<td>Post &amp; core</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2920</td>
<td>Recement crown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2980</td>
<td>Repair crown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2962</td>
<td>Porcelain veneer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2960</td>
<td>Composite veneer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAJOR TREATMENTS: BRIDGES &amp; IMPLANT CROWNS</td>
<td>Tooth no. required</td>
<td>Treatment date</td>
<td>€ Fee</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------</td>
<td>---------------</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>6242 Pontics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6752 Bridge retainer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6058 Implant crown</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAJOR TREATMENT: ROOT CANALS</th>
<th>Tooth no. required</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>3310 Root canal canine or incisor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3320 Root canal premolar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3330 Root canal molar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3220 Pulpotomy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAJOR TREATMENT: DENTURES</th>
<th>Date</th>
<th>€</th>
<th>Tooth no. required</th>
<th>(TN)</th>
<th>Date</th>
<th>€</th>
</tr>
</thead>
<tbody>
<tr>
<td>5110 Full upper</td>
<td></td>
<td>5213</td>
<td>Chrome P/-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5120 Full lower</td>
<td></td>
<td>5214</td>
<td>Chrome -/-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>567R Reline</td>
<td></td>
<td>5211</td>
<td>Acrylic P/-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>567R Repair</td>
<td></td>
<td>5212</td>
<td>Acrylic -/-</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPLANT UPGRADE</th>
<th>Tooth no. required</th>
<th>Treatment date</th>
<th>€ Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>6010 Dental implant</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORTHODONTICS</th>
<th>Date treatment commenced</th>
<th>Estimate treatment length in months (IOTN)</th>
<th>€</th>
</tr>
</thead>
<tbody>
<tr>
<td>8030 Limited ortho treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8060 Interceptive ortho treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8080 Comprehensive treatment child up to 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8090 Comprehensive treatment adult (IOTN Needed)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIC TREATMENTS: SPACE MAINTainers (CHILDREN)</th>
<th>Date appliance fitted</th>
<th>Missing tooth number(s)</th>
<th>€</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1505</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Miscellaneous items                        |                       |                          |   |
| List all other treatments not listed above  |                       |                          |   |

| TOTAL VALUE OF CLAIM                        |                       |                          |   |

---

SECTION C  DENTIST DETAILS: TO BE SIGNED BY A DENTIST
I confirm that the above patient has received the treatment detailed above.

<table>
<thead>
<tr>
<th>DENTIST DETAILS AND STAMP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>IDC/GDC number</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td>Practice phone number</td>
<td></td>
</tr>
<tr>
<td>Vhi dental network number</td>
<td></td>
</tr>
</tbody>
</table>

Collinson Insurance Solutions Europe Limited. Reg. No. C89980. Registered Office. Third Floor, Development House, St Anne Street, Floriana, FRN 9010, Malta. Collinson Insurance Solutions Europe Limited, trading as Intana is incorporated in Malta and is enrolled in the Insurance Agents List to act as Insurance Agent in terms of the Insurance Distribution Act (Cap. 487) and is regulated by the Central Bank of Ireland for conduct of business rules.