# Dental Pre-Certification

## Claim Form

## Section 1: Policy Details - for completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age).

1.1 **Quote Policy No. Here:** ☐☐☐☐☐☐☐☐ **from your Vhi membership card.**

1.2 Patient's Name: _____

1.3 Patient's Address: _____

_____

_____

_____

1.4 Policy Holder's Name: _____

1.5 Patient's Date of Birth: D D M M Y Y

1.6 Contact Telephone No.: _____

1.7 Email Address: _____

1.8 Mobile Contact No.: ☐☐☐☐☐☐☐☐☐☐

**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.

## Section 2: History of Illness - for completion by the Patient or Parent/Legal Guardian (if patient is under 18 years of age). Please place 'X' in required boxes

2.1 Name of consultant/dental practitioner first attended: _____

2.2 Date of first consultation: D D M M Y Y

2.3 Consultant's/dental practitioner's address: _____

_____

_____

2.4 When was it first made known to you that this particular treatment (which is the subject of this claim) was required? D D M M Y Y

2.5 Has this patient had this or a similar illness before? Yes ☐ No ☐

2.6 If Yes, please give date and details: Date: D D M M Y Y

Details: _____

2.7 Are any of these expenses fully or partially recoverable from any other source? Yes ☐ No ☐

2.8 If Yes, please give details:

_____

_____

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## Section 3: Patient or Parent/Legal Guardian (if patient is under 18 years of age) Authorisation

### Data Protection Statement

In order to adjudicate on your claim, Vhi will process the personal data that 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 health insurance policies, whereas some processing of your personal data is optional. You can indicate your consent to the optional processing of your personal data below.

Vhi Insurance DAC of Vhi House, Lower Abbey Street, Dublin 1 is the company that controls and is responsible for processing the personal data in relation to your claim. It 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**.

### *Obtaining Copies of Your Medical Information*

In order to process and to establish the eligibility and appropriateness of your claim we will 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.

### *Optional Consents*

We would like to process your personal data (or if you are a parent/legal guardian acting on behalf of a dependant under 18 years, the personal data you provide on their behalf) for the purposes set out below. This is entirely optional, and **will not affect the processing of the claim**.

☐ **Advisory** I consent to Vhi processing personal data in relation to this claim, and past claims, including details of any medical conditions and treatment, in order to undertake analysis and profiling of medical and health insurance needs. I understand Vhi will use this to identify individual needs, which will help Vhi to tailor communications and advice to me in connection with the renewal of my policy either by post, phone, email or SMS (based on my chosen method of communication).

☐ **Surveys** I consent to Vhi processing personal data in relation to this claim, and past claims, including details of any medical treatments, to allow Vhi to invite me to participate in surveys. If I am eligible to participate, I consent to Vhi contacting me to ask me to participate by post, phone, email or SMS (based on my chosen method of communication).

☐ **Direct marketing** I consent to Vhi processing my personal data in relation to this claim, and past claims, including details of any medical conditions and treatments, to offer me personalised products and services which are relevant to my needs by post, phone, email or SMS (based on my chosen method of communication).

### *Withdrawal of Consent*

Please note that where you have given consent to Vhi processing your personal data you may also withdraw that consent at any time. If you would like to withdraw your consent, or if you have any other queries, or if you wish to change your chosen method of communication, please contact us using any of the following channels:

- **Post:** Vhi Healthcare, IDA Business Park, Purcellsinch, Dublin Road, Kilkenny.
- **E-Mail:** info@vhi.ie
- **Phone:** (056) 444 4444
- **Online:** MyVhi or the Vhi Health Assistant App

### *Authorisation – YOU MUST SIGN HERE*

I declare that the information completed above at the time of signing this declaration is true in every respect. I authorise Vhi 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 Vhi statement of payment and I will contact Vhi 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.

**X** Signature of Patient or Parent/Legal Guardian
(on behalf of a dependant under 18 years at the time of treatment)*

_____ Date: D D M M Y Y

*For claims in relation to a dependant under 18 years at the time of treatment, please note that all correspondence and relevant payments will be made to the Policyholder. If the dependant turns 18 while the claim is in progress, Vhi will continue to correspond with the Policyholder until the claim is concluded.

Vhi Insurance DAC trading as Vhi Insurance is regulated by the Central Bank of Ireland.

**Please check that you have entered your Policy Number in Section 1.**

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**.

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## Section 4: Location of Treatment - for completion by the Consultant/Dental Practitioner (Please place '**X**' in required boxes)

For completion by the consultant/dental practitioner who will carry out the proposed treatment. To be accompanied by radiographs of sufficient clarity and detail on which to base the proposed surgery. These procedures do not ordinarily require overnight hospitalisation. Benefit is generally payable only when carried out in the following locations:

4.1 Proposed location of treatment: Dentist's Surgery ☐ Out-patient ☐ Day Case ☐ In-patient ☐

4.2 Facility Name: _____

4.3 Facility Address: _____

## Section 5: Dental Details - for completion by the Consultant/Dental Practitioner

5.1 Patient's Name: _____

5.2 Consultant's/Dental Practitioner's Name: _____

5.3 Consultant's/Dental Practitioner's Address: _____

_____

5.4 By whom was the patient referred to you? _____

5.5 Duration of symptoms: HOURS H H | DAYS D D | WEEKS W W | MONTHS M M | YEARS Y Y

5.6 Date patient first consulted you with symptoms: D D M M Y Y

5.7 Please give details of previous episodes or related problems: _____

_____

5.8 Description of examination, test, relevant findings and final diagnosis: _____

_____

## Section 6: Proposed Treatment - for completion by the Consultant/Dental Practitioner (Please place '**X**' in required boxes)

6.1 Anticipated date of treatment: D D M M Y Y

6.2 Procedure Code: ☐☐☐☐☐

6.3 Procedure Description: _____

6.4 Reason for treatment at this time: _____

6.5 If gingival and/or periodontal surgery is proposed, it is necessary to use the pocket depth chart for periodontal pocket depths of 6mm or more. The deepest pocket only should be recorded for each tooth when 6mm or more. **(N.B. Enclose relevant Radiographs, please note these dental x-rays will not be returned to you so ensure that only copies are submitted)**

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Upper** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | **8** | **7** | **6** | **5** | **4** | **3** | **2** | **1** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** |
| **Lower** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Benefit only applies when pocket depth is 6mm or more**

6.6 Indicate the reason for the method of anaesthetic (or sedation) to be employed apart from local anaesthesia: _____

_____

_____

6.7 If in exceptional circumstances, the patient is to be kept overnight, please indicate the reason: _____

_____

_____

6.8 Is any further oral/dental surgical treatment anticipated apart from the treatment described on this claim form? Yes ☐ No ☐

6.9 If Yes, please give details: _____

_____

6.10 Please confirm radiological evidence has been enclosed to support the proposed treatment: Yes ☐ No ☐

**Please append any further relevant details and/or a dental chart if appropriate for purposes of clarification.**

## Section 7: Consultant/Dental Practitioner Declaration

I hereby certify that the treatment specified was necessitated by the illness described by me above and was justified by the patient's medical condition.

| | | | |
|---|---|---|---|
| **X Consultant's/Dental Practitioner's Signature** (You must sign here) | _____ | Consultant/Dental Practitioner Code: | ☐☐☐☐☐☐ |
| | | Date: | D D M M Y Y |

## Section 8: Dental Advisor - for completion by Vhi's Dental Advisor (Please place '**X**' in required boxes)

8.1 Is information consistent with x-ray? Yes ☐ No ☐ 8.2 Is proposed treatment appropriate for benefit? Yes ☐ No ☐

8.3 Approved for Vhi Procedure Code(s): ☐☐☐☐☐

8.4 Comments: _____

_____

_____

| | | |
|---|---|---|
| **X Vhi Dental Advisor's Signature** (You must sign here) | _____ | Date: D D M M Y Y |

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# Guidelines to making a Claim

It would help us give you a speedier service and keep down administration costs if you could observe these guidelines when submitting a claim.

**Sections 1, 2 and 3** are to be completed and signed by the **Patient or Parent/Legal Guardian (if patient is under 18 years).**

**Sections 4, 5, 6 and 7** are to be completed and signed by the **Consultant/Dental Practitioner** who will carry out the proposed treatment.

**Section 8** must be completed by **Vhi's Dental Advisor.** The completed form with the radiological evidence should be submitted to Vhi's Claims Department for assessment by our dental advisors.
Please ensure that it is fully completed and that the Policy Number is shown.

- Pre-Certification is required for all procedures with an indicator of "Pre-Cert" as listed in the Schedule of Benefits for Professional Fees.
- A completed Pre-Certification Claim Form must be accompanied by supporting radiological evidence at least 3 weeks in advance of the surgery being performed.
- All applications will be assessed by our panel of Dental Advisors and a decision communicated in writing to you and our member within 10 working days. Any approval of treatment will be valid for a period of 30 working days. If the treatment has not been commenced or completed within this timeframe any approval provided will be void.
- Within 30 days of the treatment being completed you must submit your account to the address below on your headed paper, quoting the relevant Vhi Policy number, date of treatment and the pre-certification case number as outlined in our letter of confirmation.
- We will provide benefit towards the treatment in accordance with the Terms and Conditions of the member's contract with Vhi and the letter of approval provided.
- For operational and audit purposes, dental x-rays will not be returned and you should therefore ensure that only copies are submitted as part of any application.
- Where treatment is carried out in advance of approval being sought and provided, there is no obligation on Vhi to provide any benefit towards the surgery in question.

**N.B. When the account for treatment is submitted, the date on which treatment has been carried out should be clearly indicated on it.**

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## Claim Form Submission Address:

**Vhi Dental Pre-Certification Unit**
Vhi House, Lower Abbey Street, Dublin 1.

**Fax:** (01) 874 5061

**Office opening hours:** 10am-4pm Monday to Friday.

**Tel:** (056) 444 4444.
Lines open 8am-7pm
Monday to Friday
and 9am-3pm Saturday.

**Contact:** Vhi.ie
Vhi.ie/contact

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