CIGNA Dental Care
Claim Form

Download your next claim form from your member portal www.cigna.co.uk/members or CIGNA website www.cigna.co.uk/yoursolutions/memberdownloads.

CIGNA®

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:

Email Address:

Please let us know how you would like your claim paid (please tick): Cheque ☐ Bank Account ☐

Name of Account Holder(s)

Branch Sort Code __ __ - __ __ - __ __ | Bank Account No. __ __ __ __ __ __ __ __

Important Notes - Please read carefully

1. Please complete this form fully, as failure to do so could delay settlement of the claim.
2. Please consider giving us your bank account details as a direct payment to your account will improve our claims turnaround service to you. If you wish payment made directly into your bank account, you must enter your bank details on every claim form you send us (otherwise we will pay you by cheque). All bank details you provide CIGNA with will be kept secure and will only be used to pay your claim.
3. After treatment is complete, ensure that the dentist completes the reverse side of this form, outlining the treatment received.
4. 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.
5. **Then forward the completed claim form, along with the original receipts to: CIGNA Dental Claims, 1 Knowe Road, Greenock, Scotland PA15 4RJ**
   Alternatively, please scan both sides of the claim form along with the corresponding receipts and email to smyle@cigna.com. We reserve the right to request the original copies so please do not destroy these whilst the claim is being processed.
6. **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.
7. 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

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