CLAIM FORM - OralHealth (non routine treatments)

Download your next claim form from your member portal at www.cigna.co.uk/members or visit the Members page at www.cigna.co.uk

Find out more at www.cigna.co.uk/healthydiscounts

Name of member: Date of birth:

Name of patient: Date of birth:

Cigna ID number:

Name of employer/group scheme:

1. PATIENT'S DETAILS To be completed by patient. Please complete in BLOCK CAPITALS.

Address			
Town/city			
County		Postcode	
Telephone no.		Relationship to member	
Email address			
Claim settlement (please carefully read note 2 below before completing this section)			
Name of account holder(s)			
Branch sort code	- -	Bank account no.	

IMPORTANT NOTES - PLEASE READ CAREFULLY

1 Please complete this form for regular dental claims. Please complete the OralHealth (non-routine treatments) claim form for unexpected oral health problems including dental emergencies, oral cancer, hospital cash benefit and accidental damage. Complete the relevant sections as fully as possible 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 you and a qualified staff member at the dentist/specialist/hospital sign the relevant sections of this form.

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.

2. DATA PROTECTION

In order to handle your claim, we are required to process your sensitive personal information, in particular your health and medical information. If you do not provide your consent for us to process your sensitive personal information, we will be unable to handle or pay your claim.

Complete information about how we will process your information, and how you can withdraw your consent to us processing your sensitive personal information, can be found in our Data Protection Notice at www.cigna.co.uk/privacy.html.

I hereby consent to Cigna processing the sensitive personal information provided in this form in order to process my claim.

Signature of patient: _____ Date: _____

(or parent/guardian if under 13)

3. EMERGENCY TREATMENT

To be completed by the patient. Brief description of circumstances requiring emergency treatment stating whether the treatment received was for the relief of swelling, bleeding or pain.

(continue on a separate sheet if necessary)

Where did you receive your treatment? *(Please attach the relevant receipt)*	Own dentist		Other dentist	

Description of emergency treatment provided?

Date	Treatment carried out	Cost

4. TREATMENT ARISING FROM AN ACCIDENT (CONTACT CIGNA WITHIN 14 DAYS OF THE ACCIDENT - 01475 492351)

To be completed by the patient. Description of the accident and injury (continue on a separate sheet if necessary). Please note we may need to see photographs of the injury as evidence of trauma and also any official accident reports e.g. police, employer, ambulance.

To be completed by the dentist. Details of treatment provided. Please note that all treatment relating to the accident (other than emergency palliative treatment) must be pre-authorised by Cigna. A treatment plan and x-rays must be submitted to us prior to the start of the treatment. We may also request study models.

Date	Treatment carried out	Cost

5. ORAL CANCER (CONTACT CIGNA ON 01475 492351 FOR PRE-AUTHORISATION)

To be completed by the specialist. (Please attach report of definitive histopathological diagnosis following biopsy)

Date of initial consultation:		Date oral cancer diagnonsis confirmed:	

Specialist details

Name:		Telephone number:	
Address:			

6. ORTHODONTIC TREATMENT

Date:	
Treatment carried out:	
Total time span of treatment:	

7. IMPLANTS (CONTACT CIGNA ON 01475 492351 FOR PRE-AUTHORISATION)

All treatment must be pre-authorised by Cigna. A treatment plan and x-rays must be submitted to us prior to the start of the treatment

Date	Treatment carried out	Cost

Patient signature:		Dentist stamp
Date:		
Dentist's signature:		
Telephone number:		
Date:		

ACCESS TO MEDICAL REPORTS FOR YOUR CLAIMS ASSESSMENT

In this consent form, "we" means Cigna Life Insurance Company of Europe S.A.-N.V. UK Branch.

Assessing your health plan claim

We require information from your doctor/dentist to assess your claim. We therefore need access to information from your medical/dental records.

The information you and your doctor /dentist provide about your health may result in us denying your claim

We may ask you to contact your doctor if we are waiting for reports which we have asked for.

Cigna's information protection policy

We have an information protection policy in place which means we hold your information securely and access is limited to authorised individuals who need to see it. Your policy will be administered by a Cigna Group company, Cigna European Services (UK) Limited ("the administrator") and your medical/dental information will be shared with the administrator so that it may administer your policy and handle any claims you make under it.

We hold and process your personal information in accordance with data protection laws. More information about how we process your information can be found in our Data Protection Notice at www.cigna.co.uk/privacy.html.

Our Data Protection Notice is also included in your terms and conditions document which you can find in your member portal at www.cigna.co.uk/members.

If you provided us with a claim form you can request a copy at any time.

Your rights under the Access to Medical Reports Act: important notes and information

We may need to get medical/dental reports to assess your claim. Before we can ask any doctor /dentist that you have consulted to fill in a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

- You do not need to give your permission, but if you do not, we may not be able to process your claim.
- You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.
- If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.
- If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor /dentist fills in may ask about any of the following:

- Your current health.
- Any care, medication or treatment you are currently receiving.
- The results of referrals or tests you are waiting for.
- Any time off work in the last three years.
- Your past health.
- Details (excluding minor self-limiting ailments/conditions) of any relevant illness, trauma, or referrals for specialist advice or treatment, hospital admissions, consultations with your doctor /dentist or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - malignancy (cancer), cardiovascular (heart) disease, diabetes, and degenerative (gradually worsening) diseases
  - musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other
  - disorder of the joints or muscles
  - anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
- suicidal thoughts or attempts at suicide.
- conditions related to drug or alcohol misuse or smoking or chewing tobacco.
- Details of any biopsies, blood tests, electrocardiograms (heart tests), diagnostic genetic test results, height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations.
- Any blood pressure readings in the last three years.
- Any history of disease among your parents or brothers or sisters that you have told your doctor about.

We have asked your doctor not to reveal information about:

- negative tests for HIV, hepatitis B or C
- any sexually-transmitted diseases unless there could be long-term effects on your health, or
- predictive genetic test results.

If you have any questions about your rights under the act or questions relating to the process of getting, assessing or storing medical information, please write to: [Cigna Healthcare Benefits at 1 Knowe Road Greenock PA15 4RJ]

I do **not** want to see the report before it is sent to Cigna. ☐

I **do** want to see the report before it is sent to the Cigna. ☐

DECLARATION

This consent form allows us to gather medical or dental reports to support any claim made on your health or dental plan. This information may be aggregated to provide management information for business analysis.

I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess my claim. I authorise those asked to provide medical information to do so following receipt of this consent form.

By signing this declaration I am allowing you to process my claim using the reports provided, including sensitive information relating to my physical or mental health and medical conditions.

I have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act.

Signed	
Date	

Together, all the way.℠

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