



Chester House  
Harlands Road  
Haywards Heath  
West Sussex RH16 1LR

**DX 300605 Haywards Heath 2**

Telephone: +44 (0)8709 509343  
Facsimile: +44 (0)1444 450872

**DENTAL IMPLANT AFTER CARE - CLAIM FORM**

**Type of claim (please tick as appropriate)**

Failure to Integrate

Accidental Damage (Direct extra-oral impact only)

Emergency Treatment

**Notes:** Please read the following instructions before completing the claim form.

Before undertaking any treatment under this policy please check the policy Terms and Conditions (and endorsements) for details of the cover provided.

If you require any clarification please ring the Dental Team on 01444 444 957 quoting the policy number and patient name.

It is important that this form is completed fully. Any charges for completing this claim form will not be recoverable from LAMP Insurance Company Limited.

As soon as treatment becomes necessary, you must complete this form and return it to us with all the following documentation. If any supporting documentation is missing this will result in us being unable to process the claim. If you are unable to provide any of the documentation requested this may result in us being unable to accept the claim. Please use the tick boxes to indicate which supporting evidence is attached.

Evidence of original work carried out including original treatment plan, preoperative planning including any periodontal assessments, operation notes, all notes to date of event, plus full dated medical and social history and receipts for treatment

Details of the proposed remedial treatment plan with associated costs

An invoice of the amount claimed

Radiographs of preoperative conditions, implants post-placement or within three months of placement. Include CT data if obtained for planning.

X-rays of implants post restoration showing primary stability if claim is being made after exposure of implant has taken place

X-rays of implants or photographic evidence of failure (failure only)

X-rays of implant area/damage after accident has occurred but before remedial treatment is carried out (accident only)

Statement by dentist carrying out emergency/accident treatment describing the treatment given (accident and emergency only)

If accident/emergency occurred overseas evidence of time spent overseas e.g. copy of flight schedule (accident and emergency only)



**TO BE COMPLETED BY THE DENTIST**

**1. Dentist Details (please complete in block capitals)**

Policy Number:

Treating dentist details (stamp if available)

Other dentist if involved

**2. Patient details**

Title:

Mr/Mrs/Ms/Miss/Other

First Name:

Surname:

Address:

Postcode:

**3. Claim Details**

**For a claim in respect of Accidental Damage or Emergency Treatment please give details of the accident/emergency including where, when and how it happened**

Date of accident:

Time of accident:

Full description of accident:

**Please give details of accidental damage, emergency treatment or reasons for failure to integrate, including date(s) of first notification and of all related consultations**



**4. Implant details**

Implant system/type:	Diameter:	Length:	Location/Notation	Batch Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**5. Does the patient have:**

Any untreated or periodontal disease?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Signs or symptoms of bruxism or other occlusal parafunction?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Any periapically infected teeth old or new?	Notation	<input type="text"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

**6. Placement Protocols**

Placement Date:  (Tick box) Natural bone  Grafted bone

Type of transitional prosthesis used  When postoperatively was it fitted

Surgical Protocols: (tick box)

Immediate placement

Early placement  Weeks

Delayed placement  Weeks

One stage surgery

Two stage surgery

Loading Protocols: (tick box)

Immediate

Early  Weeks

Delayed  Weeks

Tilting  Degrees from axial (study models maybe requested)

Assessment of Primary Stability: (tick box)

Torque Level  Ncm

Ostell Reading

Other (state method or make comment)



Bone Defect: (tick box)

Buccal

mm

Palatal or Lingual

mm

Fenestration

mm

Augmentation material



Barrier Membrane (type)

Defect Diagram:

**7. Details of treatment (please give date, treatment and cost breakdown). Payment will only be made for work completed.**

**Date**

**Treatment provided**

**Cost**










**Date**

**Treatment to be provided**

**Cost**










**Total amount claimed:**

£

**Signature:**

**Date:**