

Claim No. _____

Premier Health

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.
Please submit completed form via Email to Medical_claims_BM@cgcoralisle.com or via Fax to 441 295 9036.

PART 1 To be completed by the EMPLOYEE/INSURED (please print)

Full Name of Insured _____

Effective and/or Termination Date (DD/MM/YY) _____

Group Policy No. _____ Certificate No. _____

Employer Name _____ Dental Plan Basic Comprehensive

Employer's Mailing Address _____ Tel. No. _____

Full Name of Patient _____

Patient's Mailing Address _____ Tel. No. _____

Patient's Date of Birth (DD/MM/YY) _____ Patient's Gender Male Female

Relationship to Insured Self Spouse Child Other _____

If the patient has other Dental Insurance coverage, provide name of policy holder and policy number _____

Name of Dentist _____

Address of Dentist _____

DECLARATION: I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, or other persons who treated me, and all hospitals or other institutions, to furnish full information including full copies of records regarding this claim to Coralisle Insurance (BVI) Ltd.

Patient's or Authorised Person's Signature _____ Date _____

ASSIGNMENT OF BENEFIT: I hereby authorise payment of the Group Insurance Benefit directly to the Dentist named below for amounts otherwise payable to me.

Patient's or Authorised Person's Signature _____ Date _____

PART 2 To be completed by the ATTENDING DENTIST (please print)

Provider ID or TIN (for US only) _____

Specialist in Orthodontics Endodontics Oral Surgery Periodontics Other _____

Date of first visit in current series (DD/MM/YY) _____ Dentist Tel. No. _____

TREATMENT DETAILS

1. If Prosthesis, is this the initial replacement? Yes No If No, date of prior replacement (DD/MM/YY) _____

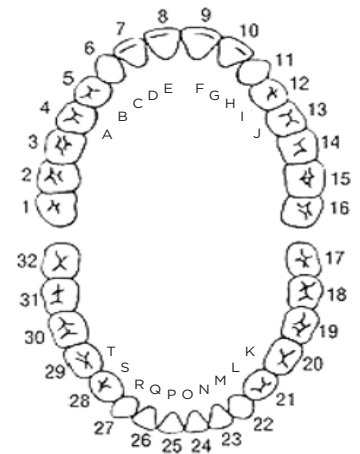
2. Is this treatment for orthodontics? Yes No If Yes, date service commenced (DD/MM/YY) _____

Date appliances placed (DD/MM/YY) _____ Months of treatment remaining _____

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NOTES:

1. Examination Details to be completed on chart below.
2. Identify missing teeth with "X" on dental plan to right.
3. If services cannot be completed within 90 days from date of examination, patient must obtain a new authorisation and Claim Form for uncompleted services.
4. A pre-operative and post-operative x-ray of root canal work is required. Post-operative bite-wing x-rays must be provided when requested by Coralisle Insurance (BVI) Ltd.



PART 3 EXAMINATION AND TREATMENT PLAN

List in order from tooth no. 1 through no. 32, using chart system shown

TOOTH No. OR LETTER	SURFACE	DENTAL CODE	DESCRIPTION OF SERVICE (Include x-rays, prophylaxis, materials used, etc.)	DATE OF SERVICE (DD/MM/YY)	FEE
INSTRUCTIONS					TOTAL FEE CHARGED

INSTRUCTIONS

Tooth No/Letter Using the tooth chart above, please indicate applicable tooth

Dental Code (see Part 6) i.e. D#####; e.g., D0120 = Periodic oral eval - established patient

PART 4 DENTIST’S CERTIFICATION FOR SERVICES PROVIDED

I have been paid. Yes No I certify the above items (no. of items _____) were provided and completed by me.

Signature _____ Date _____

PART 5 DECLARATION (To be signed by the Patient AFTER all the work is complete.)

I hereby certify that the procedures as indicated by "Date of Service" have been completed to my satisfaction.

Patient's Signature _____ Date _____

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PART 6 COMMON DENTAL PROCEDURE CODES

Note: Codes are for reference purposes only, not a summary of benefits.

DIAGNOSTIC		ENDODONTICS	
Oral Evaluations		Pulpotomy	
D0120	Periodic oral evaluation - established patient	D3220	Therapeutic pulpotomy (excl. final restoration)
D0140	Limited oral evaluation - problem focused	Endodontic Therapy (Root Canals)	
D0150	Comprehensive oral evaluation - new established patient	D3310	Endodontic therapy, anterior tooth (excl. final restoration)
D0160	Detailed and extensive oral evaluation, problem focused by report	D3320	Endodontic therapy, premolar tooth (excl. final restoration)
D0180	Comprehensive periodontal evaluation	D3330	Endodontic therapy, molar tooth (excl. final restoration)
Xrays/Radiographic Images		PERIODONTICS (SURGICAL SERVICE)	
D0210	Intraoral - complete series of radiographic images	Surgery	
D0220	Intraoral - periapical first radiographic image	D4260	Osseous surgery - four or more contiguous teeth or per quadrant
D0230	Intraoral - periapical first radiographic image	D4261	Osseous surgery - one to three contiguous teeth or per quadrant
D0240	Intraoral - occlusal radiographic image	D4263	Bone replacement graft, retained natural tooth, first site in quadrant
D0270	Bitewing - single radiographic image	Periodontal Scaling and Root Planing	
D0272	Bitewings - two radiographic images	D4341	Periodontal scaling and root planing - four or more teeth per quadrant
D0274	Bitewings - four radiographic images	D4342	Periodontal scaling and root planing - one to three teeth per quadrant
D0330	Panoramic radiographic image	D4355	Full mouth debridement to enable a comp oral eval/diag on a subsequent visit
CASTS		Other Periodontic Services	
D0470	Diagnostic casts	D4910	Periodontal maintenance
PREVENTIVE		Prostodontics (Dentures)	
Routine Cleanings		D5110	Complete denture (maxillary)
D1110	Prophylaxis - adult	D5211	Partial denture - resin-based (maxillary)
D1120	Prophylaxis - child	D5212	Partial denture - resin-based (mandibular)
Other Preventive Service		D5650	Add tooth to existing partial denture
D1206	Topical application of fluoride with varnish	D6240	Pontic - porcelain fused to high noble metal
D1208	Topical application of fluoride excl. varnish	IMPLANTS	
D1351	Sealant - per tooth	D6010	Surgical placement of implant body: endosteal implant
RESTORATIVE		D6240	Add tooth to existing partial denture
Fillings - Amalgam		ORAL AND MAXILLOFACIAL SURGERY	
D2140	Amalgam - one surface, primary or permanent	D7111	Extraction, coronal remnants - primary tooth
D2150	Amalgam - two surfaces, primary or permanent	D7140	Extraction, erupted tooth or exposed root
D2160	Amalgam - three surfaces, primary or permanent	D7210	Extraction, erupted tooth requiring removal of bone
Fillings - Resin		D7220	Removal of impacted tooth - soft tissue
D2330	Resin-based composite - one surface, anterior	D7230	Removal of impacted tooth - partially bony
D2331	Resin-based composite - two surfaces, anterior	D7240	Removal of impacted tooth - completely bony
D2332	Resin-based composite - three surfaces, anterior	D7250	Removal of residual tooth roots (cutting procedure)
D2335	Resin-based composite - four or more surfaces	ORTHODONTICS	
D2391	Resin-based composite - one surface, posterior	D8030	Limited orthodontic treatment of the adolescent dentition
D2392	Resin-based composite - two surfaces, posterior	D8040	Limited orthodontic treatment of the adult dentition
D2393	Resin-based composite - three surfaces, posterior	D8070	Comp. Orthodontic treatment of the adolescent dentition
D2394	Resin-based composite - four or more surfaces, posterior	D8080	Comp. Orthodontic treatment of the adult dentition
Crowns		Repair	
D2710	Crown - resin-based composite (indirect)	D8696	Repair of orthodontic appliance - maxillary
D2740	Crown - porcelain/ceramic	D8697	Repair of orthodontic appliance - mandibular
D2750	Crown - porcelain fused to high noble metal	MISCELLANEOUS SERVICES	
D2751	Crown - porcelain fused to predominantly base metal	D9110	Palliative (emergency) treatment of dental pain - minor procedure
D2752	Crown - porcelain fused to noble metal	D9222	Deep sedation/general anesthesia - first 15 minutes
D2792	Crown - full cast noble metal	D9223	Deep sedation/general anesthesia - each subsequent 15 minutes
Other Restorative Services			
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		
D2920	Re-cement or re-bond crown		
D2930	Pre-fabricated stainless steel crown - primary tooth		
D2940	Protective restoration		
D2950	Core build-up, including any pins when required		
D2952	Post and core in addition to crown, indirectly fabricated		
D2954	Prefabricated post and core in addition to crown		