

# DENTAL CLAIM FORM

Dental Discretionary Cover is provided via Incolink's Discretionary Fund and is governed by the Discretionary Guidelines

**OFFICE USE ONLY**

Claim number

Reference

**COMPLETE THIS FORM IF**

You or your dependant have suffered ACCIDENTAL DAMAGE to sound and healthy teeth, **outside working hours**. Incolink guidelines will be followed when assessing this claim.

**FORWARD THIS CLAIM FORM TO**

**Total Claims Solutions**  
Level 1, 151 Rathdowne Street  
Carlton VIC 3053

**FOR CLAIM ENQUIRIES CALL**

**Total Claims Solutions**  
(03) 9320 8588

**INSTRUCTIONS**

**Section A**

The **WORKER** must complete ALL questions in Section A (pages 1-3) of the form. Incomplete answers and vague information will delay the assessment of the claim. This claim must be supported by proof of identity.

**Acceptable Documents**

1. A current Australian drivers license, or
2. A current Australian passport

**Section B**

The **TREATING DENTIST** must complete Section B (pages 4-5) only if Section A is complete. The worker will be responsible for any fee charged to complete this statement.

**IMPORTANT**

The **ORIGINAL** fully completed claim form must be sent with **ALL DOCUMENTS** outlined in the checklist.

**CHECKLIST**

- Proof of dependant(s) – *if any*
- Rebate Receipts – *if any*
- Quotation(s)/Invoices(s)
- Treatment Plan(s) – *if any*
- Proof of identity

The issue of this form **DOES NOT** constitute admission of liability on our behalf.

**Section A**

**Worker**

**WORKER DETAILS**

1. Incolink member number  2. Are you a union member?  No  Yes  Name of union

3. Given name(s)  Surname  4. Date of birth  DD / MM / YYYY

5. Street Address (no PO Box)  Suburb  Postcode

6. Home phone  7. Mobile  8. Email

9. Marital status  Married  Defacto  Single  10. Sex  Male  Female

11. Occupation  12. Do you require an interpreter?  No  Yes  Language

**CLAIMANT DETAILS**

13. Person claiming  Worker  Spouse/Defacto/Child   Defacto – Attach a copy of at least one bill confirming the same residence.  Student over 16 – Attach a copy of the student's ID card.

**Dependants means;**  
The worker's spouse (or partner with whom the worker has resided for not less than 3 consecutive months), or the unmarried financially dependant children of the worker up to 16 years of age or up to 25 years of age if a full time student.

14. Name of person claiming (if not worker)  15. Date of birth  DD / MM / YYYY

**PLEASE ATTACH DOCUMENTATION**

**WORKER'S EMPLOYMENT DETAILS**

16. Name of company

17. Phone

18. Date commenced

19. Employment status

 Full-time  Part-time  Casual  Apprentice  Working Director  Sub-Contractor

20. Are you office-based?

 Yes  No

21. Are you a union delegate?

 Yes  No

22. Are you still employed?

 Yes  No▶ Date of termination **ACCIDENT DETAILS**

23. Date of accident

24. Exact time of accident

25. How did the accident occur and what were the surrounding circumstances?

26. Describe the damage to your teeth

27. Is the damage to a denture, plate or bridge?

 No  Yes

▶ Dentist or dental technician who fitted them

Phone

Address

Age of denture/plate/bridge

28. Where did the accident occur

 Home  Work  Travelling to/from work  Other

29. Address where accident occurred

30. Name of witness(es)

Phone

1. 2. 

31. Had you consumed any alcohol or drugs in the 8 hours prior to the accident?

 No  Yes

▶ Location

Amount

32. Did the accident occur while training for or playing sport?

 No  Yes

▶ Club name

Phone

33. Details of the dentist you first consulted for this accident

Dentist Phone Date treated Address 

34. Details of the dentist who treated you prior to this accident

Dentist Phone Date treated Address **PLEASE SIGN DECLARATION – OVER PAGE**

**OTHER BENEFIT DETAILS**

The Incolink Dental Program requires all dental claims to be lodged through your private health insurer or travel insurer in the first instance.

35. Do you have private health insurance?

No  Yes ▶ Is dental cover included?  No  Yes ▶ Has a claim for this treatment been lodged with this insurer?  
 No  Yes ▶ Please provide rebate statements

36. Did the accident occur overseas?

No  Yes ▶ Have you lodged a claim with your travel insurer?  No  Yes ▶ Insurer  
 Phone  
 Claim number

37. If claiming for your child aged between 2 to 17 years of age, are you eligible to claim the 'Child Dental Benefits Schedule' with Medicare?  
If unsure, please check with Medicare if your child is eligible.

Yes  No

**PLEASE ATTACH A COPY OF ALL REBATE STATEMENTS**

**PAYMENT DETAILS**

38. If this claim is accepted, how would you like to receive payment(s)

Pay funds directly to Dental Clinic/Dentist  
 Forward a cheque payable to myself  
 Electronic Funds Transfer to myself ▶ Please provide your banking details.

**We depend on the accuracy of the details you provide. Please write clearly and contact your bank if you are unsure of these details.**

Bank name  
 Account name Account type  
 BSB Account number

I (name in full) ..... hereby authorise Total Claims Solutions Pty Ltd to pay my benefits directly into my bank account.

Signature Date DD / MM / YYYY

**DECLARATION AND AUTHORISATION**

**CLAIMANT:**

I hereby authorise any dentist, employer or any other relevant person, to furnish Total Claims Solutions Pty Ltd with any information including all current and prior history relevant to this claim.

I authorise Total Claims Solutions to give or obtain information relating to my claim from any insurer and/or private health fund, statutory authorities, or their representatives.

I authorise Total Claims Solutions to give or obtain information from my employer.

I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

I understand that supplying false or misleading information will result in my right to compensation being forfeited.

I declare that the information provided on this claim form is to the best of my knowledge and belief to be true in every respect.

**Please note**, if under 18 years of age, a guardian must sign authority.

Signature

Print name

Date

**WORKER:**

I hereby authorise for Incolink to furnish Total Claims Solutions Pty Ltd with details of my employer payments to assist with the claim

Signature

Print name

Date

Total Claims Solutions manage the Discretionary Dental Claims on behalf of Incolink



PATIENT DETAILS

THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE CHARGED TO COMPLETE THIS STATEMENT

1. Name 2. Age 3. Occupation

4. Address

ACCIDENT DETAILS

5. Date the patient first consulted you

DD / MM / YYYY

6. Describe the damage to the tooth/teeth

7. Was the damaged tooth/teeth sound and healthy prior to the accident?

Yes No Provide details

8. What damage was caused by the accident

Tooth structure only Existing restoration only Both Other

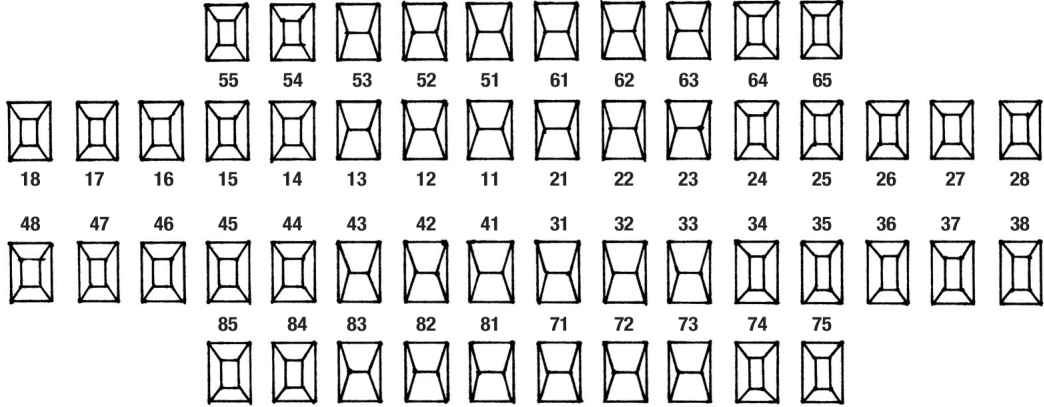
9. Did the accident result in damage to a denture/plate/bridge?

No Yes Were you the dentist who provided them originally? No Yes Age of denture/plate/bridge

10. Type of denture

Acrylic Cast metal frame Full upper Full lower Partial upper Partial lower

11. On the following diagram, please circle the damaged tooth/teeth



12. If the patient is a child, was the damage sustained to the milk or permanent tooth/teeth?

TREATMENT DETAILS

13. Please give details as to the status of the patient's tooth/teeth

14. Has the patient ever had the same or a similar condition?

No Yes When Impact on current treatment proposed

CONTINUE OVERPAGE

15. Is the treatment proposed/performed solely due to the accident?

Yes  No



Provide details

Dashed box for providing details for question 15.

16. Is any further treatment required?

No  Yes



Provide details

Dashed box for providing details for question 16.

17. Please advise the circumstances of the patient's accident and how the tooth/teeth was damaged

Two solid rectangular boxes for providing details for question 17.

18. Did the accident occur at work?

No  Yes



Provide details

Dashed box for providing details for question 18.

19. Was the patient playing in competitive sport at the time of the accident?

No  Yes



Provide details

Dashed box for providing details for question 19.

20. Do you believe the patient was under the influence of alcohol or drugs at the time of the accident?

No  Yes



Provide details

Dashed box for providing details for question 20.

21. Are you the patient's regular dentist?

Yes  No

22. Does the patient have Private Dental Insurance?

No  Yes



Insurer

Phone

Dashed box for providing details for question 22.

23. If the patient is a child and aged between 2 to 17 years old, is the patient eligible to claim the 'Child Dental Benefits Schedule' with Medicare?

No  Yes



Please advise amount available towards the treatment

Dashed box for providing details for question 23.

**DECLARATION BY DENTIST**

I hereby declare that the information I have provided on this form is to the best of my knowledge and belief, true in every respect.

Name

Medical qualifications

Signature

Date

Address

Phone

Fax

Email

STAMP box

**PLEASE ATTACH A COPY OF THE TREATMENT PLAN/QUOTATION AND/OR INVOICE**

**Total Claims Solutions Pty Ltd** ABN 42 389 515 023  
Acting as Claims Managers on behalf of Incolink  
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