PACIFIC CROSS
VIETNAM

The strength behind your insurance

DENTAL CLAIM FORM

(All sections must be completed)

SECTION A – PARTICULARS OF THE PATIENT

Name of Patient: ______________________________ Sex: __________

Date of Birth (day/month/year): __________ Member No.: __________ Policy No.: __________

If group insurance, name of the Policyholder: ______________________________

SECTION B – STATEMENT BY THE PATIENT

1. If any the above treatments or services were necessitated as a result of an accident, please state the occurrence of the incident.

____

____

2. When and where did the accident occur?

____

____

____

3. Was the accident of nature requiring report to the police?

   If so, was the accident reported? ❑ Yes ❑ No
   When and where was it reported?

____

SECTION C – AUTHORIZATION & DECLARATION

I hereby authorize any hospital or dentist or other person who has attended me to furnish to insurance company (and its representative) and permit the said insurance company (and its representative) to review any and all information requested with respect to any illness, or accident, dental history, consultation, prescription or treatment and copies of all hospital or dental records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

I hereby declare to the best of my knowledge and belief that the particulars stated on this form to be true and correct.

I understand that if I fail to provide any information requested in this form, it may result in the inability of the Company to accept or process this claim.

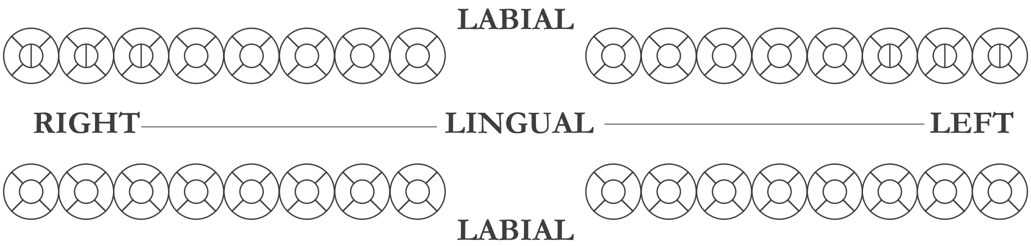
______________________________ ______________________________

Date (day/month/year) Signature of Patient (or Parent if a minor)

SECTION D- ATTENDING DENTIST'S REPORT

Treatment Date	Treatment Provided	No. of Tooth	Charges
1. ________	________	________	________
2. ________	________	________	________
3. ________	________	________	________
4. ________	________	________	________
5. ________	________	________	________
6. ________	________	________	________
7. ________	________	________	________
8. ________	________	________	________
9. ________	________	________	________
10. ________	________	________	________

Please mark teeth treated or area of oral treatment on the following chart:



Name of Dentist: ____________________

Address: ____________________

____

Telephone No.: ____________________

E-mail: ____________________

____

Signature of Dentist

Date (day/month/year): ____________________

** Please attach all invoices and other relevant documents*

SECTION E - PAYMENT DETAILS

a. Payment to Policyholder / Insured Person

Preferred payment method

- ❑ Cash
- ❑ Bank Transfer (Please fill in the VND bank details below)

Account Holder’s Name: ____________________

Account No.: ____________________

Bank Name: ____________________

Bank Address: ____________________

b. Payment to Medical Provider

Has direct billing been agreed with **Pacific Cross Vietnam** ? ❑ Yes ❑ No