Dentist Declaration

This Declaration needs to be completed by the treating dentist.
Please use BLOCK CAPITALS and Black Ink when completing the form.

This section may only be completed by a dentist who is trained, qualified, and licensed to practice dentistry by the licencing authority of the country in which you receive treatment. We reserve the right to withhold benefit for treatment by dentists who do not hold internationally recognised qualifications and training (for example, a medical school listed in the World Health Organisation's World Directory of Medical Schools).

If you are receiving treatment from your dentist, please ensure that you take this form with you for them to complete. Once completed you can upload this together with a copy of the invoice and receipt via our on-line claims portal at www.expacare.com/submit-a-claim. **Please contact us on +44 (0) 1344 233900 if you have any questions.**

First name: Last name:

Telephone: Email:

Membership Number: Date of birth: DD / MM / YY

1. Treatment Date: DD / MM / YY
2. Prior to the present treatment, please advise when the patient last attended a dental inspection where all treatment was concluded:
3. What treatment has been received by the patient this visit?
4. Has all necessary treatment concluded? Yes ☐ No ☐
   If not please list planned treatment?
   If this is a claim for restorative treatment after an accident, we will write to you requesting the information we need.
5. Declaration:
   Signature of dentist:
   Date: DD / MM / YY
   Telephone number:
   Fax number:
   Email address:
   Name and Address:

   Practice stamp: