PACIFIC CROSS
excellence at every contact

DENTAL CLAIM FORM

(All sections must be completed)

Please send all claims and inquiries to: **International Administrators Limited**
16/F, 9 Des Voeux Road West, Sheung Wan, Hong Kong, SAR
Tel: (852) 2573 2535 Fax: (852) 2573 2917
E-mail: inquiry@ialhk.com Website: http://www.pacificcross-insurance.com

SECTION A – PARTICULARS OF THE PATIENT

Name of Patient		Sex
Date of Birth (MM/DD/YY)	Member No.	Policy No.
If group insurance, name of the Policyholder		

SECTION B – STATEMENT BY THE PATIENT

1. If any of 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 **PACIFIC CROSS INSURANCE COMPANY LIMITED** (or its representative) and permit the said insurance company (or 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 photostat 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.

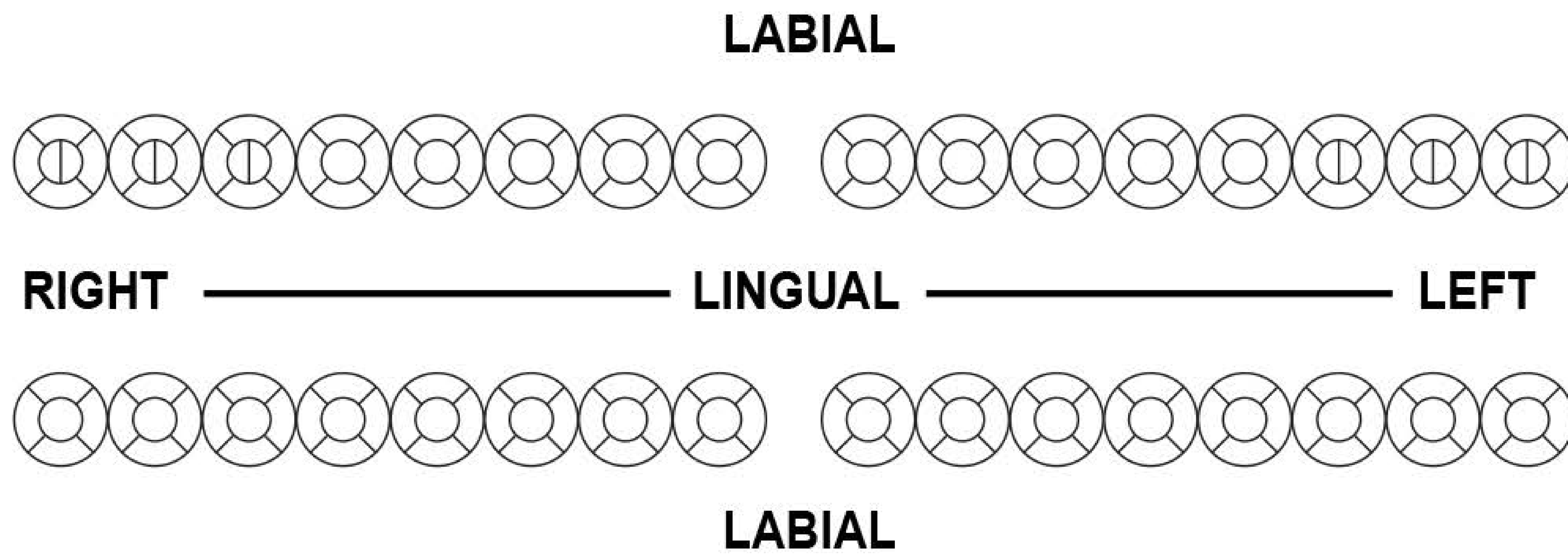
I understand that if I fail to provide any information requested in this form, it may result in the inability of the Company to accept or process this claim.

Date	*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: ______________________

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Telephone No.: ______________________

E-mail: ______________________

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Signature of Dentist with Stamp

Date: ______________________

Please attach all invoices and other relevant documents.