Fondo Sanitario Integrativo del Gruppo Intesa Sanpaolo

InSalute SERVIZI

REFUND FORM FOR DENTAL EXPENSES

(In the case of a family unit, use one form for each person)

This form must be sent to:
FONDO SANITARIO INTEGRATIVO DEL GRUPPO INTESA SANPAOLO
Ufficio Liquidazioni c/o InSalute Servizi
Via San Francesco D'Assisi 10,10122 Torino (TO)

Together with a photocopy of medical and expenses documentation*

☐ **The undersigned asks for a REFUND**

☐ **Working Members/Affiliated working members**	☐ **Retired Members/Affiliated retired members**

PERSONAL DATA OF THE POLICY HOLDER

Surname_____**Name**_____

Born in_____**on**_____**Gender** ☐**M** ☐**F Tax Code**_____

Phone_____**Cell**_____(fill in if you intend to use the service "FOLLOW YOUR CLAIM")

E-mail_____@ _____

ID Number_____**Company Name** _____

PERSONAL DATA OF THE FAMILY MEMBER FOR WHICH A REFUND IS REQUESTED

Surname_____**Name**_____

Born in_____**on**_____**Gender** ☐**M** ☐**F Tax Code**_____

Space reserved to long absentee members, early retired or retired members for documentation return

Address_____n._____City_____(_____)

Services for which a refund is requested:
The dentist will have to subscribe the service(s) for which the refund is requested by filling in the details on the form enclosed herewith.

Herein find attached **COPY** of the following invoices:

	Invoice/ Receipt number	Issued by	Invoice/ Receipt date	Amount
1				.
2				.
3				.
4				.
5				.
6				.
7				.

Total amount requested net of stamp duty (if present on the expense document):	.

*** The Plan reserves the right to ask for original documentation in the 5 (five) years following the invoices financial year, in order to carry out statutory verifications.**

OTHER INSURANCE COVERAGE / ACCIDENT COVERAGE WITH THIRD-PARTY LIABILITY

(The failure to complete this section will entail the rejection of the request.)

Reference to the Treatment Regulations – General Rules – Paragraph V:

"In the presence of charges reimbursable by the National Healthcare Service, the reimbursement and/or permanent advance by third parties - including following accidents caused by the same - or in the presence of other, similar coverage for oneself and/or for family-member beneficiaries, the undersigned has the obligation to provide formal notice thereof to the "Fondo Sanitario" (Healthcare Plan) that will pay for the treatments, net of the amount reimbursed and/or advanced. Should the participant instead intend to request, in first instance, the reimbursement from the "Fondo Sanitario", the reimbursement will occur on a definitive basis and without application of a deferred portion, in an amount equal to 50% of the amount due in application of these Treatment Regulations"

The undersigned declares that the expenses sustained: *(check box applicable)*

☐ are not covered by another other form of insurance or referable to an accident with third-party liability;

☐ are covered by another form of insurance or are referable to an accident with third-party liability and accordingly requests, in first instance, of the n, the final payment of 50% of the sum due;
The expenditure sustained, net of any deductible, will be settled in the amount of 50% on a definitive basis and without application of any deferred portion.

☐ are covered by another form of insurance or are referable to an accident with third-party liability and accordingly, requests in second instance, of the Plan, the settlement of the expenditure remaining for the undersigned's account.
The expenditure remaining for the account of the undersigned will be settled for 100%, should the same be less than or equal to the maximum limits reimbursable according to the criteria in effect and with application of the deferred portion, if provided. Attach the settlement letter of the other insurance, indicating the detail of the expenditures reimbursed. In this case, the deadline for the presentation of the request is extended, with respect to the ordinary deadline, to 90 days from the date of the reimbursement obtained from third parties.

Signature of Policyholder_____

In the event of **HOSPITALISATION,** complete the following section:

Hospital stay: from_____to_____ ☐ **With surgery** ☐ **Without surgery** ☐ **Daily allowance**

Invoices referring to ☐ **Pre-hospitalisation** ☐ **Hospitalisation** ☐ **Post-hospitalisation**

N.B.: In the event of **HOSPITALISATION IN A PRIVATE FACILITY,** the medical records must be attached.

No. documents attached to this application (invoices, medical records, certificates of hospital stay, etc.): _____

Date of completion:_____ **Signature of Policyholder**:_____

Signature of beneficiary of the treatment_____

(*if a minor, signature of the parent or guardian)*

Consent to the processing of personal data – Italian Legislative Decree no. 196/2003

The undersigned, in relation to the disclosure statement already received pursuant to Article 13 of LD no. 196/2003, consents to: the processing of his/her personal data, including sensitive data, acquired or to be acquired as part of the Healthcare Plan's statutory purposes; the communication of such data to the persons indicated in the disclosure statement; and the Plan's communicating and making visible the data to the member which made the undersigned a beneficiary.

Date of completion: _____

Name and surname _____

Signature for Consent of Beneficiary of Treatment _____

(*if a minor, signature of the parent or guardian)*

QTY	SERVICE		QTY	SERVICE
PREVENTION			**SURGERY**	
	Periodic oral evaluation			Simple tooth or root extraction
	Emergency visits (with emergency surgery)			Complex tooth or root extraction (or in partial bone inclusion)
	Occlusal or intra-oral x-ray or bite – wing			Tooth or root extraction in complete bone inclusion
	X-ray: for each further radiogram		**PROSTHESIS**	
	Prophylactic/simple tartar ablation - Adult			Prosthesis crown in LNP or ceramic
	Prophylactic/simple tartar ablation – Child			Prosthesis crown in LP and ceramic
	Fluorine topical application (Prophylactic excluded) - Child			Prosthesis crown in full ceramic
	Fluorine topical application (Prophylactic excluded) – Adult			Temporary simple resin prosthesis crown
VISITS				Pivot (fused/premade/carbon fiber)
	Oral check, specialist visit			Upper resin full prosthesis
	Oral hygiene			Lower resin full prosthesis
RADIOLOGY				Upper partial resin prosthesis (up to 3 elem. Including clamps)
	Front – rear or lateral cranium and facial bones x-ray			Lower partial resin prosthesis (up to 3 elem. Including clamps)
	Dental orthopantomography (OPT)			Removable prosthesis in stellitic alloy up to 3 elem. – upper arch.
CONSERVATION				Removable prosthesis in stellitic alloy up to 3 elem. – lower arch.
	Sealing (for each tooth)			Removable prosthesis clamp
	Compound or amalgam filling (1-2 surfaces)			Prosthesis repair
	Compound or amalgam filling (3-5 surfaces)			Add. Element on partial prosthesis or on removable prosthesis
PARADONTOLOGY				Prosthesis definitive lowering, upper total prosthesis indirect technique
	Roots scalling and honing (up to 6 teeth)			Prosthesis definitive lowering, lower total prosthesis indirect technique
	Extra coronal dental wiring (4 teeth)			Prosthesis definitive lowering, upper total prosthesis direct technique
	Gingivectomy (for 4 teeth)			Prosthesis definitive lowering, lower total prosthesis direct technique
	Gingivectomy per tooth			Precision joint in LNP
	Simple gingival flap for 4 teeth		**ORTHOGNATODONTICS**	
	Mucus flap/ging. repos. apic./couret. open (4 teeth)			Case study
	Rizectomy per root (including access flap)			Ort. Therapy fixed braces per arch/year (teenagers)
ENDODONTICS				Ort. Therapy fixed braces per arch/year (adults)
	Crown pulp amputation and pulp cavum filling (deciduous)			Ort. Therapy removable braces per arch/year
	Intra oral therapy 1 root canal (including diagnostic x-ray)			Orthodontic visit with modelling
	Intra oral therapy 2 root canal (including diagnostic x-ray)			Night bite
	Intra oral therapy 3 root canal (including diagnostic x-ray)		**IMPLANTOLOGY**	
				Bony stable implant (including premade pillar)
OTHER:				

☐ OPTION IS RESERVED SOLELY **TO SERVICE MANAGEMENT** SUBSCRIBERS
I hereby request the possibility to dispose of the coverage cap of **€ 5.250** merging the ceiling for the current year (net of eventual already received reimbursements) and for the two following years. The services provided refer to a care plan for which I enclose a **single invoice** of an amount equal or superior to € 7.500.

Teeth numbers layout

RIGHT UPPER ARCH I QUADRANT									LEFT UPPER ARCH II QUADRANT							
18	17	16	15	14	13	12	11		21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41		31	32	33	34	35	36	37	38
RIGHT LOWER ARCH IV QUADRANT									LEFT LOWER ARCH III QUADRANT							

Services list

Service	Quantity	Tooth/Teeth	Arch	Notes

Date of completion_____ **Dentist signature and stamp**_____