Fondo Sanitario Integrativo del Gruppo Intesa Sanpaolo

InSalute SERVIZI

REQUEST FOR REIMBURSEMENT FOR DENTAL EXPENSES

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

FONDO SANITARIO INTEGRATIVO DEL GRUPPO INTESA SANPAOLO

Claims Office c/o InSalute Servizi

Via San Francesco d'Assisi 10, 10122 Torino

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_____ @_____

Company Name_____

ID Nember_____

Personal Data of the Family Member for Which the Reimbursement is Requested

Surname_____ **Name** _____

Born in _____ **on**_____ **Gender M F Tax Code** _____

Reserved for members on long-term absence, in exile, or in retirement for the return of the documentation.

Address_____ n._____ City_____ (_____)

Services for which a refund is requested:

The dentist will have to specify the service(s) for which the refund is requested by filling in the details on the enclosed form.

Here in find attached **COPY*** of the following invoices:

	Invoce/Receipt number	Issued by	Invoce/Receipt date	Amount
1				,
2				,
3				,
4				,
5				,
6				,
7				,

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

***The Fund reserves the right to request the original expense documentation within five (5) years following the year to which the invoices pertain, for the verifications required by the regulations.**

Fondo Sanitario Integrativo del Gruppo Intesa Sanpaolo

InSalute SERVIZI

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 the 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 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 the first instance of the Plan, 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 the 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 Policy holder**: _____
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.

Completion date: _____

Name and surname _____

Signature of the Beneficiary's Consent for Treatment _____
(*if a minor, signature of the parent or guardian)*

Service Description	Qty	Amount
GENERAL SECTION		
1st oral visit		
- 1^ oral visit - supragingival tartar removal - instruction and motivation for oral hygiene - preparation of the medical history form and any treatment plan		
- 1^ oral visit - tartar removal - instruction and motivation for oral hygiene - orthopantomography or complete radiographic assessment - photographs of the oral cavity - preparation of the medical history form and treatment plan (subject to possible re-evaluation during treatment)		
Periodic or dental check up		
Dental visit with emergency treatment		
Visit with diagnostic laser equipment (Diagnodent, Diagnocam) and preparation of medical history form and treatment plan		
Visit with autofluorescence for identifying oral cancer lesions		
Supragingival tartar removal beyond the first session		
Scaling and root planning, for hemiarch		
PARODONTOLOGY		
Interdental splint for periodontal issues or post-orthodontics (custom or prefabricated devices)		
Guided bone regeneration surgery for hemiarch (including heterologous bone and membrane)		
SURGEY		
Clinical crown lengthening		
Apicoectomy, including root canal treatment and/or retrograde filling		
Disimpaction of retained teeth (per element, any technique)		
Simple extraction of tooth or root		
Complicated extraction of a tooth or root (including alveolar cleaning, fibrin application, suturing, and stitch removal)		
Guided bone regeneration intervention post-extraction on a single element (including heterologous bone and membrane)		
Extraction of partially bony impacted third molar (including mucogingival flap, osteotomy, odontotomy, suturing)		
Extraction of full bony impacted third molar (including mucogingival flap, osteotomy, odontotomy, suturing)		
Open gingival surgery with scaling and root planning for hemiarch		
Abscess incision (including dressings)		
Frenulectomy labio-tectal (also with laser technique)		
Lingual frenectomy (also with laser technique)		
Frenulotomy (also with laser technique)		
Fornix deepening (repositioning of the vestibular fornix pre-prosthetic, per arch		
Pre-prosthetic surgery (removal of fibromatosis, mucosal hypertrophies, reduction of exostoses, bone remodeling post-extraction, also with laser-assisted techniques), pre-prosthetic for quadrant		
Removal of oral neoplasms (fibromas, mucous cysts, small benign or malignant neoplasms, mucoceles possible separate biopsy examination)		
Post-removal biopsy examination of oral lesions		
Gingivectomy on a single element (regardless of pathology)		
Gingivectomy/Gingivoplasty on multiple elements (for hemimandible regardless of pathology)		
Laser treatment of lip or cheek angiomas (also in multiple sessions)		
Removal of epulis		
Rhizectomy or rhizotomy in a single procedure		
Crown exposure of dental element (any technique)		
CONSERVATIVE		
Composite inlay of any type		
Ceramic inlay of any type		
Class I or Class V filling (Black's classification)		
Class II filling (Black's classification)		
Class III filling (Black's classification)		
Class IV filling (Black's classification)		
Pulp capping		
Tooth reconstruction with endodontic posts (any technique and material)		
Reconstruction in composite		

PEDODONTICS		
Filling of deciduous tooth		
Extraction of deciduous tooth		
Pulpotomy with capping of the canal pulp of deciduous tooth		
Fissure sealing (perSealant of grooves (per element)		
Fluoride prophylaxis		
Oral hygiene instruction (child and parent) with gadget		
Oral hygiene instruction (teenagers aged 12 to 16)		

ENDODONTICS		
Endodontic treatment of single canal tooth (including pre-treatment reconstruction, canal closure by any technique, intraoral radiographs)		
Endodontic treatment of double canal tooth (including pre-treatment reconstruction; canal closure by any technique, intraoral radiographs)		
Endodontic treatment of triple or multi-canal tooth (including pre-treatment reconstruction; canal closure by any technique, intraoral radiographs)		
Endodontic retreatment of tooth (including pre-treatment reconstruction; canal closure by any technique, intraoral radiographs) PER CANAL		
Removal of intracanal post prior to endodontic retreatment		

IMPLANTOLOGY		
Osteointegrated implant (any type, including surgical guide, subsequent prosthetic abutment)		
Mini implant (small diameter, definitive placement, transmucosal, including precision attachments)		
Large sinus floor elevation for hemimaxilla (including heterologous bone graft, membrane)		
Mini sinus lift for implant purposes (concurrent with implant placement, implant excluded)		
Autologous bone harvesting for implant or periodontal purposes		

FIXED-PROSTHESIS		
Crown in alloy and ceramic (L.P or L.N.P)		
Metal-free ceramic crown		
Temporary crown in direct or indirect resin		
Temporary crown reinforced with metal closure		
Removal of crown for single abutment tooth		
Maryland Bridge in metal resin or metal ceramic (for one element)		
Screw-retained prosthesis on implants, for arch type Toronto bridge, All on 4, All on 6; excluding implants		
Definitive reconstruction of endodontically treated tooth with cast or prefabricated post (any type)		

REMOVABLE -PROSTEHESIS		
Partial temporary removable prosthesis with clasps (for arch, including clasps)		
Framework denture with metal structure (any type) and resin or ceramic elements up to 5 elements		
Total temporary removable prosthesis for arch		
Total definitive removable prosthesis for arch		
Framework denture with metal structure (any type) and resin or ceramic elements over 6 elements		
Single clasp on framework		
Precision attachment on framework (2 components)		
Direct rebasing of total or partial removable prosthesis		
Indirect rebasing of total or partial removable prosthesis		
Repair of removable prostheses		

GNATHOLOGY		
Selective grinding (also in multiple sessions) per element		
Postural examination (including basic tests and gnathological evaluation)		
Impression taking and study models		
Postural deprogramming (long-term treatment, including follow-up visits, initial, intermediate, and final electromyography, study models, diagnostic bite, rehabilitative gnathological bite		
Postural examination with stabilometric platform		
Postural reprogramming with Taopatch (also in ATM function)		
Electromyographic examination		
Kinesio graphic examination		
Pre bite Pelosi		
Night guard		
Diagnostic bite		
Rehabilitative gnathological bite (including follow-ups)		
Incisal rise bite		
Occlusal rise splint (SnapOn type) including annual check-ups		

ORTHODONTICS		
"All Inclusive" orthodontic treatment with fixed or removable appliances per arch and per year. Includes check-ups, adjustments, and any final retention appliance		
"All Inclusive" orthodontic treatment with clear aligners per arch and per year. Includes check-ups, adjustments, and any final retention appliance		
Interceptive pre-orthodontic therapy one-time fee		

RADIOLOGY		
Radiograph or bite wings for up to two elements		
Orthopantomography of both arches		
Cephalometric radiography of the skull		
Dental scan or cone beam volumetric tomography (one arch)		
Dental scan or cone beam volumetric tomography (two arches)		

THREE YEAR PLAFOND ONE TIME FEE

☐ **For registered service management**: I request the option to utilize the maximum amount of €5.250 by combining the plafond of the current year (net of any reimbursements already utilized) and the two following years. The services refer to a treatment plan amounting to €7,500 or more (net of any tartar removal or oral hygiene).

☐ **For registered inactive members**: I request the option to utilize the maximum amount of €2.250 by combining the plafond of the current year (net of any reimbursements already utilized) and the two following years. The services refer to a treatment plan amounting to €3.300 or more.

N.B. *To request the three-year plafond, check the box and submit the final invoice, along with any advance invoices, provided that no more than 12 months elapse between the first advance invoice and the final invoice. The expense can be divided into a maximum of 4 invoices.*

List of Services

Service	Quantity	Tooth/Teeth	Arch	Amount

Date of completion _____

Dentist's signature and stamp _____