NHS

Replacement Appliance Refund Claim Form

FP17R/11

14/11/12

Regulation 11 of The National Health Service (Dental Charges)(Wales) Regulations 2006
Regulation 11 of The National Health Service (Dental Charges) Regulations 2005

Part A

PLEASE COMPLETE IN BLOCK CAPITALS

Patient's Details

Surname

Forename

Address

Date of Birth Day Month Year

Sex **Male** **Female**

Postcode

Parent/Guardian's Surname (if this patient is under 16)

Initial

Title

Part B

I wish any refund to be paid into the following bank account:

Name(s) of account holder(s)

Full name of bank, building society or other acount provider

Sort code of the bank, building society or other acount provider - -

Account number

If a building society account, the building society roll or refernce number

Some building society accounts use a roll or reference number. The number is on the passbook. If you are not sure if the account has a roll or reference number, ask the building society. Incorrect bank account details will delay any refund you are entitled to.

Tick this box if you do not have an account

Part C

(Part C must be completed by the dentist)

Provider Name, Address and Location Number:

Part D

Date appliance provided Day Month Year

Date charge paid

Charge paid £

(A receipt must be enclosed)

Part E

Please describe the steps you took to take care of this appliance prior to it being lost or damaged beyond repair and how it was lost or damaged:

Part F

☐ **The original appliance was not lost or damaged due to lack of reasonable care by the patient or the patient's parent/guardian.**

Part G

☐ **This charge will cause me undue financial hardship.**

Please send proof that you received one of the following benefits or a copy of the exemption certificate you are named on, otherwise it will take longer to process your claim.

On the date the charge was paid I was named on one of the following certificates:

☐ NHS Tax Credit Exemption Certificate

☐ NHS Low Income Scheme HC2 Certificate

☐ NHS Low Income Scheme HC3 Certificate which limits the amount paid to: £

Please provide details of the certificate you hold:

Certificate number:

Dates the certificate is valid for:

From Day Month Year to Day Month Year

On the date the charge was paid, I, or my partner, was in receipt of one of the following benefits:

☐ Income Support

☐ Income-Based Jobseeker's Allowance

☐ Income-Related Employment and Support Allowance

☐ Pension Credit Guarantee Credit

Please provide the FULL name, date of birth and National Insurance Number of the person receiving the benefit:

Forename

Surname

National Insurance Number

Date of Birth Male ☐ Female ☐

Please explain why paying this charge will cause you undue financial hardship

When completed please send this form to the:
NHS Business Services Authority, 1 St Annes Road, Eastbourne, East Sussex, BN21 3UN

Patient's Declaration:

I hereby claim a refund of the charge paid for a replacement NHS dental appliance.

I declare that the information I have given is correct and complete. I understand that if it is not, appropriate action may be taken. To enable the NHS to check I am entitled to help with NHS charges and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form by and to the NHS Business Services Authority, Primary Care Trust/Local Health Board, Department for Work & Pensions, HM Revenue & Customs and this dental contractor or practitioner.

I am the patient ☐ or parent/guardian ☐ named overleaf

Signature: _____

Print Name

Date: _____