

This form should only be completed if a replacement appliance has been approved

Part A

Patient's Surname

Date of Birth

Day Month Year

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Forename

Sex

Male

Female

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

Initial

Title

Address

Postcode

Part B *(Part B must be completed by the dentist)*

Provider Name, Address and Location Number:

Part C

Date appliance provided

Day Month Year

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Date charge paid

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Charge paid

£

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(A receipt must be enclosed)

Part D

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 E

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

Part F

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, or my partner, was in receipt of one of the following benefits:

- Income Support
- Income-Based Jobseeker's Allowance
- Pension Credit Guarantee Credit

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

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			to		
Day	Month	Year	Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

When completed please send this form to the:

NHS Business Services Authority, Dental Practice Division, Compton Place Road, Eastbourne, East Sussex, BN20 8AD

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 and HM Revenue & Customs.

I am the patient or parent/guardian named overleaf

Signature: _____

Date: _____