DKV

ATTESTATION OF DENTAL CARE
S152 E

1. SECTION TO BE FILLED OUT BY THE INSURANT

☐ **Individual policy nr.**

☐ **Group policy nr.** **Affiliation nr.**

IBAN nr. - - -

BIC nr.

2. SECTION TO BE FILLED OUT BY THE DENTAL OR MEDICAL PRACTITIONER

Name / first name patient:

2.1. PERFORMANCES – EXCEPTING FIXED PROSTHESES *

Date of treatment	Social Security performance(s) code(s) or description performance	Nrs. teeth or nr. prosthesis	Paid fee

2.2. PERFORMANCES REGARDING FIXED PROSTHESES *

Date of treatment	Description performance	Nrs. teeth	Paid fee
	Dental Implant		
	Abutment		
	Dental post and core build-up		
	Single crown		
	Bridge - Abutment(s)		}
	- Pontic (s)		
	Inlay / Onlay		
	Others (Describe please):		

TOTAL €

*** THESE PROSTHESIS COSTS ARE BASED UPON THE TREATMENT SCHEDULE DATED:** / / 20

In accordance with the insurance conditions, no refund of these costs is provided unless prior approval of the treatment schedule by the insurer.

I hereby certify that I provided the above mentioned treatment and received the concording fee(s).

Signature, name and stamp of the dental or medical practitioner (INCL. PHONE NR)

General overview, only the general and tariff insurance conditions and the special policy conditions are binding. The applicable General and Tariff Conditions are available at www.dkv.be.

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