



APPLICATION FOR PAYMENT OF A DENTAL CLAIM OR APPROVAL IN ADVANCE OF A PLAN FOR DENTAL TREATMENT



Upon completing this form, please send it by email to services@harel-ins.co.il along with any necessary documentation.

Type of application: Request for payment of a dental claim Request for approval of a dental treatment plan Inquiry

Date: / /

1 Details of the Physician

| | | |
|----------------------------|-----------------------------|------------------------------------|
| Number of physician/clinic | Address of physician/clinic | License no. of attending physician |
| Clinic telephone number | Physician's cellphone | Name of attending physician |

2 Details of the Patient

| | | | | |
|---------------------|---------------|--------------------------|------------------|------------------|
| Identity number | Policy number | Additional policy number | Telephone number | Cellphone number |
| First name | Last name | Address: Street | House number | City |
| E-mail address | | | | |

We will send updates about the progress in handling the claim to the email address you provided above. If you did not provide a new address, we will send all the updates to the address in our records from previous claims. In any other case, we will send the updates by Israel Post.

3 Details for transfer of funds after approval of the claim

| | | | | |
|--|--|--------------|--|--|
| Cellphone number for transfer of payment to patient's Bit account (age 18 and up) | Important: Please note that if we do not receive a cellphone number for Bit and confirmation of Bit or a bank account number, we will not be able to execute payment of the claim. | | | |
| We will wait for confirmation that you received the payment. If we do not receive confirmation, we will transfer the payment to the bank account as provided here: | | | | |
| Bank account number of the patient for bank transfer (age 18 and up) | | | | |
| Bank account number | Branch number | Name of bank | | |

We request that you enter the procedure code and reason code according to the list on the next page. If a reason code does not appear, it is not necessary to list one.

4 Procedure Details

The inclusion of X-rays is required according to the procedure, as listed on the other side of the page - Instructions for Completion of the Form)

On the other side of this page, we include a table of procedures and reasons for the procedure. We have marked the places in which you are required to attach X-rays.

| Procedure code | Reason code | From tooth | To tooth* | Mark the filling surfaces with an x | | | | | | Date of completion of the procedure (for claim or inquiry only) | Amount paid for the procedure | Invoice number** | |
|----------------|-------------|------------|-----------|-------------------------------------|---|-----|---|---|---|---|-------------------------------|------------------|--|
| | | | | CL/V | B | L/P | D | O | M | | | | |
| 1. | | | | | | | | | | | | | |
| 2. | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | |

*The column "to tooth" refers to restorative/periodontic procedures. **Attach an original tax invoice to the claim.

5 Physician's Comments

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6 Declarations and Confirmation by the Patient

It is known to me that it is not possible to claim a refund for the same amounts from different parties (such as other insurance companies or HMOs) and receipt of double refunds is a violation of the instructions of the law and the instructions of the insurance policy. My signature is confirmation and an undertaking on my part that I will report to Harel Insurance Company any monetary payment I receive from any other party in regard of this invoice, and I hereby allow Harel Insurance Company to make any examination whatsoever regarding my entitlement to a refund/compensation in regard of this invoice.

By signing, I confirm my waiver of medical confidentiality in favor of Harel and instruct the provision of any information from my medical file and/or the medical record from any institution as necessary to the Insurer in order to settle my request. I have and will not have any complaint and/or claim to any party in regard of this request of mine.

Date:

Signature of the Insured:



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| Reason Code | Procedure name | Procedure code | X-Ray | |
|----------------------------------|---|----------------|--------|-------|
| | | | Before | After |
| Diagnosis | | | | |
| | Periodic oral assessment - known patient | D0120000 | | |
| | Bitewing X-rays - 2 X-rays | D272000 | X | |
| | Periapical X-ray | D0220000 | X | |
| | Panoramic X-ray | D0330000 | X | |
| | Full status x-ray | D0210000 | X | |
| | Full dental status X-ray using paralleling technique | D0210020 | X | |
| | Cephalometric X-ray | D0340000 | X | |
| | Tomography of temporomandibular joint | D0322000 | X | |
| | Mouth/face X-rays | D0350000 | X | |
| | Diagnostic casts, die and study model | D0470000 | | |
| Prevention | | | | |
| | Preventative treatment - adult, removal of layer, plaque and stains in permanent and transitional dentition | D1110000 | | |
| | Fissure seals, for each tooth | D1351000 | | |
| Preservative Dentistry | | | | |
| | Restoration of amalgam, 1 surface, primary or permanent dentition | D2140000 | | |
| | Complex restoration on resin/acrylic basis, 1 surface, frontal | D2330000 | | |
| Root Canal | | | | |
| | Root canal - not including final restoration | D3310000 | X | X |
| | Renewal of root canal | D3346000 | X | X |
| Reasons for RC/Renewed RC | | | | |
| 51 | RC due to caries | | | |
| 52 | RC as result of a process | | | |
| 54 | RC as a result of a gum problem | | | |
| 57 | RC for prosthetic/aesthetic purpose | | | |
| 81 | Renewed RC for prosthetic purpose | | | |
| 82 | Renewed RC a result of a process | | | |
| 83 | Renewed RC as result of incomplete RC | | | |
| | Pulpotomy of primary or permanent tooth | D3220000 | X | |
| | Apexification | D3351000 | X | |
| Surgery | | | | |
| | Extraction, erupted tooth or exposed root, 1 tooth | D7140000 | X | |
| | Surgical extraction - tooth erupted into mouth | D7210000 | X | |
| | Surgical extraction - tooth impacted in soft tissue | D7220000 | X | |
| | Surgical extraction - tooth fully impacted in hard tissue | D7240000 | X | |
| Reasons for Extraction | | | | |
| 60 | Extraction due to extensive crown decay | | | |
| 63 | Extraction due to a gum problem | | | |
| 64 | Extraction for orthodontal purpose | | | |
| 67 | Extraction for prosthetic purpose | | | |
| 68 | Extraction of extra tooth | | | |
| | Apicoectomy (root end surgery) | D3410000 | X | |
| | Hemi-section | D3920000 | X | |
| | Incision and draining of tooth abscess - in soft tissue in mouth | D7510000 | X | |
| Other procedure | | | | |
| | First aid - treatment of toothache | D9110000 | X | |
| | Permanent space maintainer - insertion | D1510000 | X | |
| | Prefabricated stainless steel crown - primary tooth | D2930000 | X | |

| Reason Code | Procedure name | Procedure code | X-Ray | |
|---|--|----------------|--------|-------|
| | | | Before | After |
| Diagnosis | | | | |
| | Core buildup ,including different kinds of pins | D2950000 | X | |
| | Cast post and core in addition to crown | D2952000 | X | X |
| | Porcelain crown fused to predominantly base metal | D2751000 | X | X |
| | Reasons for restorative procedure | | | |
| 10 | Structure/crown after root canal | | | |
| 11 | Structure/crown for aesthetic reasons | | | |
| 12 | Structure/crown as result of crown destruction | | | |
| 13 | Bridge due to extraction | | | |
| 14 | Replacement of restoration due to RC/renewed RC | | | |
| 15 | Replacement of restoration for aesthetic reasons | | | |
| 16 | Replacement of restoration due to caries | | | |
| 17 | Replacement of restoration after extraction | | | |
| Dentures and Repairs | | | | |
| | Partial denture, upper jaw on resin base | D5211000 | X | |
| | Removable partial denture of vitallium | D5213000 | X | |
| | Complete denture | D5213000 | X | |
| | Adding a tooth to an existing partial denture | D5650000 | | |
| | Adding a clasp to an existing partial denture | D5666000 | | |
| | Repair broken complete denture base | D5510000 | | |
| | Adding a tooth to an existing partial denture | D5650000 | | |
| | Repair denture cast framework (soldering) | D5620000 | | |
| | Rebase complete denture | D5710000 | | |
| | Reline complete maxillary denture - clinic | D5730000 | | |
| | Reline complete maxillary denture - lab | D5750000 | | |
| | Labial veneer (resin laminate) | D2960000 | X | |
| | Precision/semi-precision attachment to permanent partial denture | D6950000 | X | |
| | Root coping | D2975000 | X | |
| Upper jaw tooth mark 97, lower jaw, tooth mark 98 | | | | |
| Implants | | | | |
| | Surgical placement of dental implant, including exposure | D6010000 | X | X |
| | Prefabricated dental implant | D6056000 | X | X |
| | Porcelain crown fused to predominantly base metal | D6060000 | X | X |
| Orthodontics | | | | |
| | Partial straightening of transitional dentition | D8020000 | X | |
| | Comprehensive straightening of adult dentition | D8090000 | X | |
| | Partial straightening of adult dentition | D8040000 | | |
| Periodontics | | | | |
| | Comprehensive periodontal evaluation - new or known patient | D0180000 | | |
| | Incision and drainage of abscess/cyst (periodontal) | D7510000 | X | |
| | Extra-coronal stabilization of loose teeth (composite material) | D4321000 | X | |
| | Crown lengthening | D4249000 | X | |
| | Periodontal scaling and root planning - 4 or more teeth | D4341000 | | |
| | Periodontal surgery including shaping bone - 4 or more teeth | D4260000 | | |
| | Raising flap, including root planing | D4240000 | X | |
| Any other procedure not defined in the table | | | | |