

Dental Trauma (injury)

It is important that your Request for Assistance, where possible, has been pre-authorized prior to submission. To obtain pre-authorization, please contact the Assistance Team on 0300 303 5065 or outside normal working hours call the Dental Helpline on 0800 525 631 (UK) or 0044 1747 820841 (outside the UK).

The admission of a request by the Worldwide Dental Emergency Assistance Scheme is at the sole and absolute discretion of the Scheme Manager.

If admitted, your request will be considered by the Scheme Manager, against the schedule set out in the Scheme Handbook, which provides a guide to the level of benefits to which you may

be eligible. You will need to meet any other costs charged by the treating dentist.

Please ensure you have read the Scheme Rules and associated Benefit Schedule to ensure you are familiar with any limitations or exclusions that may apply to your request. A copy is available at <http://scheme.dpas.co.uk/patients>

Please provide as much information as possible to ensure your request is processed efficiently and promptly.

- A Request for Assistance Form must be completed by you (and the treating dentist where specified) and must be submitted within 30 days of the trauma or emergency incident, together with an itemised receipt or invoice from the treating dentist.
- You must at your expense, provide any reports, certificates, information and evidence that is relevant to support your request.
- We may request copies of your dental records, photographs, x-rays or other supporting documentation in the processing of your request.
- If a request for treatment abroad is admitted we will pay benefits in Pounds Sterling using FX Converter at www.oanda.com. The exchange rate will be calculated at the rate in force on the date of the payment unless evidence of Sterling conversion value is submitted with your request.
- The Scheme Manager reserves the right to recover the cost of a request admitted by the Scheme from any third party.
- Payment of the benefit is normally made direct to the dentist providing the treatment, but can be made to you if you have directly incurred costs.

YOUR DETAILS

Title: _____ Forename(s): _____ Surname: _____ DOB: _____

Address: _____

Postcode: _____

Home phone: _____ Daytime phone: _____ Dental Plan Registration No: _____

If you would like correspondence regarding your request sent by email please provide your email address:

Email: _____

Are you covered by, or claiming under, any other insurance/scheme in relation to this incident? Yes No

Details if yes: _____

Have you made any previous claims under any dental insurance policy/scheme? Yes No

If yes, please give details and dates: _____

YOUR REGISTERED DENTIST DETAILS

Title: _____ Forename(s): _____ Surname: _____

Practice Name: _____

Address: _____

Postcode: _____

Practice phone: _____ E-mail: _____

YOUR TREATING DENTIST/CONSULTANT DETAILS (if different from above)

If you are a registered DPAS dentist, please insert the practice reference number: _____

Title: _____ Forename(s): _____ Surname: _____

Practice Name: _____

Address: _____

Postcode: _____

Practice phone: _____ E-mail: _____

Request information

EMERGENCY TEMPORARY TREATMENT

How did your dental emergency occur? _____

Date and time of emergency treatment: _____

What treatment/advice was given? _____

If you were abroad: Date of leaving the UK: _____ Date of return to the UK: _____

Did you contact the Dental Helpline or Assistance Team? Yes No

Did the dentist have to open his or her surgery to treat you? Yes No

Have you incurred a call out fee? Yes No If yes, call out fee: £ _____

You may claim emergency treatment costs if away from home or for dental injury. Please provide details of the treatment below:

TOOTH	DETAILS	POLICY CODE	COST
e.g. UL6	Resecure crown	18	£29.20

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DENTAL TRAUMA

Date and time of incident: _____ Incident place: _____

How did your dental trauma occur? _____

What damage did you notice within seven days of the incident? _____

Were there any witnesses? Yes No

If yes, please give names and addresses: _____

Was the incident reported to anyone in authority, such as your employer or the police? Yes No

If yes, please give the person's name and details: _____

Were any existing implants damaged? Yes No

Do you have a DPAS Dental Implant Accident Protection Policy? Yes No

If yes, please provide your policy number: _____

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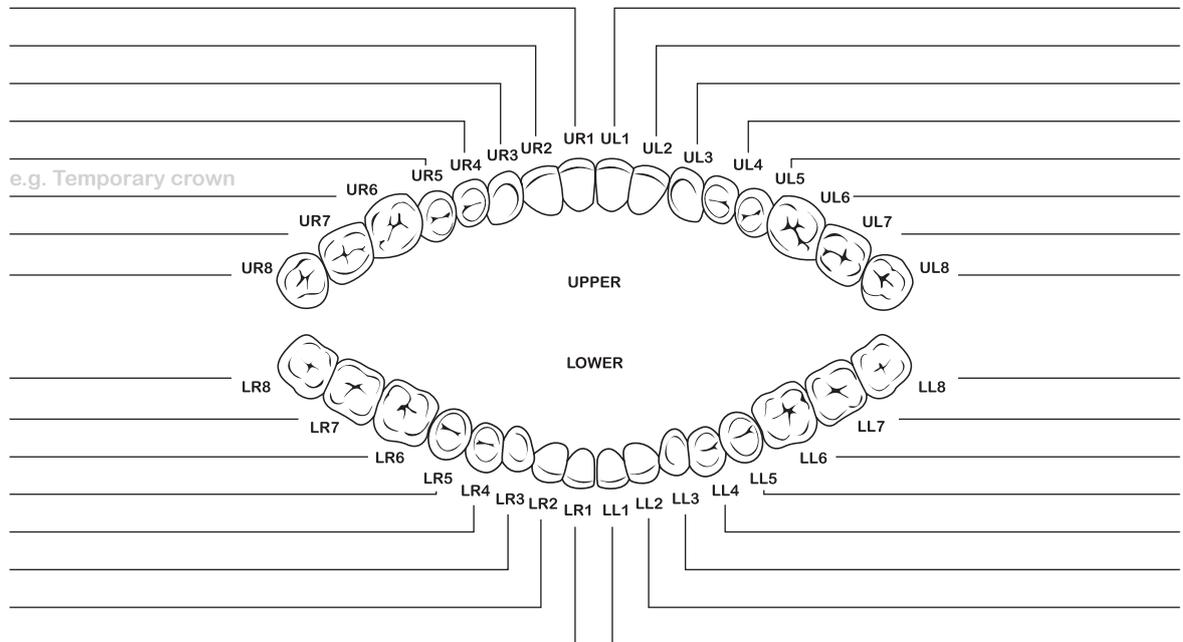
Treatment information – dental trauma

Please ask your dentist to complete this section of the claim form.

Date treatment started: _____ Date treatment completed: _____

Please indicate on the diagram below:

- Details of pre-existing conditions i.e. existing bridge/crown etc Trauma sustained, and to which teeth



What treatment has been given?

TOOTH	DETAILS	POLICY CODE	COST
e.g. UL6	Temporary crown	20	£53.30
TOTAL			

If ongoing treatment is required, please give details of planned treatment, expected costs and a copy of your dental treatment plan:

TOOTH	DETAILS	POLICY CODE	COST
e.g. UL6	Crown – Porcelain jacket	6	£300
TOTAL			

I have enclosed the required x-rays and/or photos Yes No

If no, please state reason: _____

Additional notes: _____

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Payment information

PLEASE ENCLOSE ORIGINAL RECEIPTS IF YOU HAVE ALREADY PAID THE DENTIST'S ACCOUNT.

Payment should be made to:

- Patient** – Payment will be made directly to the account from which your dental plan payments are requested
- Your DPAS registered dentist** – Account details are not required for DPAS dentists, as payment will be made directly to the bank account as shown on our records
- Non-DPAS treating dentist** – If the treating dentist is not a DPAS provider please complete the account details section below
- Other** (please state name and reason for alternative payee)

Alternative account details:

Account Name: _____ Bank Name: _____

Account Number: _____ Sort Code: _____

DENTIST DECLARATION

Are you the patient's registered dentist? Yes No

If no, are you on the emergency rota? Yes No

Dentist's signature: _____

Name (please print): _____ **Date:** _____

If the patient has a receipt for emergency treatment overseas/away from home, a dentist signature is not required.

PATIENT'S DECLARATION – ALL PATIENTS MUST SIGN

I hereby consent for the Scheme Manager of the Worldwide Dental Emergency Assistance Scheme to:

- be provided with full access to my dental records and give authority for a full report to be supplied to them
- contact a medical practitioner/consultant to obtain information required for the processing of this request
- contact and share information with other scheme/insurance providers in relation to this request
- reclaim any benefits paid in error.

I understand that the information supplied will be used for underwriting and fraud prevention purposes, which may include the Worldwide Dental Emergency Assistance Scheme passing such details to agents or other scheme providers/insurers. I hereby declare that these particulars are true to the best of my knowledge.

Patient's signature: _____ Parent Guardian

Name (please print): _____ **Date:** _____

THE SCHEME MANAGER, CAMBRIAN WORKS, GOBOWEN ROAD, OSWESTRY, SHROPSHIRE SY11 1HS

Telephone: 0300 303 5065 **Email:** assistance@wdeas.co.uk
General enquiries relating to your dental plan: 01747 870910

Registered address:

Worldwide Dental Emergency Assistance Scheme is operated by Worldwide Assistance Ltd.
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